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ABSTRACT

The final report describes goals and activities of the Family Resource Center, an educational and therapeutic program using a family treatment approach to child abuse. Among family treatment programs considered are intake, behavior management counseling, recreational therapy, supportive services, and diagnostic remedial and behavior management classrooms. Also discussed are the program's research component, volunteer activities, and community and professional education efforts. (CL)

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Final Report

on

Family Resource Center
4386 Lindell Blvd.
St. Louis, MO 63108

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funded by
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PROJECT GOAL STATEMENT

The goals for the three years of the program remained fairly stable throughout the funding periods. 2nd continue to provide a framework for the agency, Although the goals were too ambitious to be completely acheived, the Center did make gains in all areas. Subgoals and progress in meeting them are elaborated in seperate sections of this report.

1. To develop a family treatment approach which will reduce the incidence of abuse in FRC families by providing an educational and therapeutic environment for both parents and children.

11. To improve the child abuse service network in the metropolitan St. Louis Community through establishing referral procedures with agencies for FRC families, indentifying the nature and scope of FRC services for the agency network, involving agency staff in FRC meetings and initiating plans with agencies to expand services for abusive families.

111. To provide a community education program which will develop greater awareness of the prolem, improve the process of identifying and reporting suspected cases, improve attitudes toward abusive parents and their children, and encourage community support for programs servicing this population.

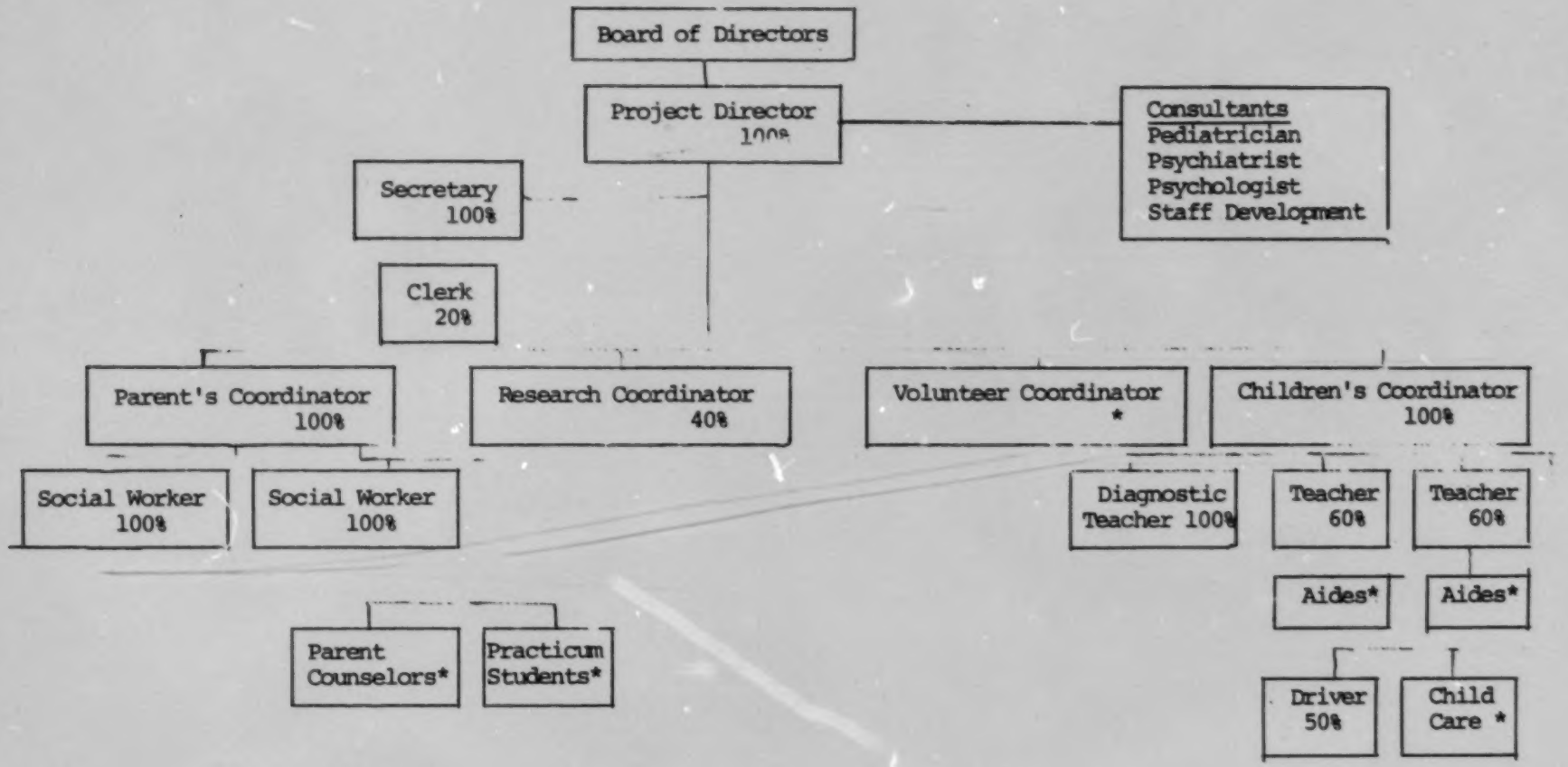
1V. To organize programs for professional, student, and lay workers involved with abuse children and their parents.

V. To expand the relevant knowledge base pertaining to child abuse.

Table 1

FAMILY RESOURCE CENTER

Organizational Chart



* Indicates volunteer positions

Population Description

Table 2 shows the abuse/neglect status, and demographic characteristics of the clients seen at the Center during the three years that the grant was in effect. Although emotional abuse and neglect, potential abuse, and mild injury were the most frequent problems seen at the intake phase, severe and moderate injuries and death due to abuse account for 41% of the physical abuse cases.

The 89 families had a total of 178 children. The children were almost evenly divided between males and female with males representing 55% of the total. The modal age group for both males and females was four years for the boys and five years for the girls.

The Center has data on 89 mothers and 45 fathers. Seventy-four percent of the mothers were between 20 to 29 years ole. While 53% of the fathers fell into this age range, and 44% were older. Out of 89 families, 56% (50) had two adults present and the majority of the two-adult families represented legal marriages (44). In 10 families, the parents were were divorced. Parents were predominantly caucasion with this category accounting for 57% (51) of the mothers and 64% (29) of the fathers. Thirty-seven percent (33) of the mothers and 33% (15) of the fathers were negro. Race was not known for 38% of the fathers.

Sixty-four percent (57) of the mothers were unemployed. In contrast 75% (34) of the fathers were employed full time and only 18% (8) were unemployed. Not surprisingly, 49% of the families had incomes below $6,000. The modal income range was $2,000 - 3,000 and the median income was just over $6,000. Income was unknown for 25% of the families.

TABLE 2

Abuse Status
and Demographic Characteristics

Severity of Cases

Abuse		Neglect	
7	Severly Injured	4	Severly Neglected
7	Moderately Injured	3	Moderately Neglected
23	Mildly Injured	8	Mildly Neglected
30	Emotional Abuse	21	Emotional Neglect
1	Sexual Abuse	1	Failure to Thrive
32	Potential Abuse	2	Potential Neglect
2	Death Due to Abuse		

Age and Sex of Children

Age	Male	Female
1	12	10
2	10	5
3	20	13
4	12	9
5	7	10
5+	37	33

Approximate Age
Parent-Parent Substitute

	Mother	Father
Under 20	5	1
20-24	33	9
25-29	33	15
30-34	10	12
35-39	5	4
40+	0	4
unknown	3	

Marital Status of Parent(s)/Parent Substitute

44	Legal Marriage	3	Marriage Partner Temporarily Absent
6	Consensual Union	1	Marriage Partner Permanently Absent
10	Never Married	3	Unknown
21	Divorced		
1	Widow		

Level of Education

	Mother	Father
No high school degree	29	15
High School Degree	39	21
Some college or Vocational Training	14	7
College Graduate	1	0
Post Graduate	0	2

Table 2 Continued

Ethnicity/Race of Parent(s)/Parent Substitute(s)

	Mother	Father
Caucasion	51	29
Black	33	16
Spanish Surname	1	0
Other	3	0

Employment of Parent/Parent Substitute

	Mother	Father
Employed full-time	9	34
Employed part-time	11	3
Unemployed	5	8
Unknown	12	

Terminated Cases

Estimated Yearly Family Gross Income

1 - 1,999	15
2,000 - 3,999	17
4,000 - 5,999	12
6,000 - 7,999	9
8,000 - 9,999	8
10,000 -14,999	4
15,000 -19,999	1
over 20,000	22

INTAKE

Referral

During the grant period, a total of 351 referrals were made to the project (see Table 3). The distribution of referral sources remained fairly constant with the exception of one source. During the first year the state protective agency - Division of Family Services - referred 25% which increased to 38% in year two, and 44% in year three. The majority of these referrals 85% were from the St. Louis office and the remainer from St. Louis county. The second major referral source was St. Louis Children's Hospital which referred 25% in the first year and 17% in the second. No referrals were received in the third year. The third source of referrals were parents themselves. For each year the percentages increased from 18 to 25 to 35 respectively. These increases were encouraged through media programs and advertising through social agencies. The other referral sources varied from legal agencies to private social agencies. Regardless of the referral source, the majority of FRC families were voluntary referrals. The average number of court ordered families was 6% of the caseload.

Intake Criteria and Procedures

The project did not establish formalized intake criteria until midway in the grant period. . Clearly, the project emphasized services for abusive families. Only a few neglect families were accepted due to the lack of resources to provide for the needs of this population.

The project reveiwed all referrals in a weekly intake meeting during which worker assignments, decisions (to accept for treatment or to refer), and initial treatment plans were made. The project improved on this format and continued to use after expiration of the grant period.

Therapists scheduled initial sessions at the Center or in the parent's home depending upon the parent's preference. Extended home visitation or outreach service was provided for parents who were fearful and/or resistive to investing themselves in a therapy program.

The duration of the intake phase varied over the course of the project. Initially, extended intakes (three to four sessions) were conducted. The purpose of the sessions was to build parent's investment in a treatment program and to establish bonds with one staff person. During that period, most often the intake worker continued as the parent's therapist. This system appeared effective for the project and the parent. Due to some staff expansion and reluctant parents, the outreach phase extended at times over a period of months. This resulted in a difficult transition for parents into the treatment program. Later the project decreased the number of outreach clients and shortened the intake time period.

Unfortunately this reduction was too severe and parents were assigned to therapy without sufficient time for assessment and preparation for treatment Finally, the pendulum did return to a middle point where

TABLE 3

ANNUAL INTAKE REVIEW: REFERRAL AGENCIES

MAY 1974 thru FEBRUARY 1977

REFERRAL SOURCE	MAR 1974 thru FEB 1975	MAR 1975 thru FEB 1976	MAR 1976 * thru April 1977	TOTAL
Children's Services	0	9	5	14
Circuit Court	0	2	0	2
Community Agency	7	3	12	22
Division of Family Services	18	60	53	131
Hospitals	1	8	2	11
Juvenile Court	4	5	2	11
St. Louis Children's Hospital	18	27	0	45
Self	13	40	42	95
Other	10	5	5	20
Total	71	159	121	351

* Represents partial - Project closed intake from Feb.-May 1977 until funding sources were secured.

staff conducted an average of three intake sessions with parents.

Recommendations

As this discussion suggests, we found intake to be one of the most complex areas of the program and also to be a critical variable as to the success of a treatment program. Intake workers must possess the necessary diagnostic skills to assess not only adult behaviors but family interactions and child behaviors as well. In some cases, outreach extended because the worker did not appropriately assess the family or present the information at the intake meetings. When employing a family intake model, well defined procedures for integrating parent and child workers must be utilized to assure a family assessment and not merely adult and child assessments. In part this can be facilitated by workers conducting joint sessions. In addition, at least one intake session should involve all members of the family whether or not each member is designated in need of services.

Finally, coordination with existing agencies serving the family is necessary not only for a complete social history but also to insure a cohe sive treatment plan

TABLE 4

ANNUAL DISTRIBUTION OF ADULT SERVICES

MAY 1974 thru FEBRUARY 1977

SERVICE	Unit of Measurement	MAY 1974 - FEB 1975	MAR 1975 - FEB 1976	MAR 1976 - April 1977	TOTAL
Behavior Management	contacts	n/a *	126	238	364
Counseling by FRC	contacts	49	381	701	1,131
Crisis Intervention - Day	contacts	37	254	173	464
Family Conferences	conferences	7	37	32	76
Family Therapy	sessions	1	48	112	161
Group Therapy	sessions	15	134	373	522
Hotline	contacts	n/a	61	80	141
Individual Therapy	sessions	52	198	344	594
Marital Therapy	sessions	1	98	119	218
Parent Counselors	contacts	26	333	529	888
Psychiatric Consultations	sessions	n/a	5	7	12
Recreational Therapy	sessions	n/a	10	8	18
Transportation	trips	94	736	922	1,752
Total		282	2,42[illegible]	3,638	6,341

* not applicable for the period

Group Therapy

Family Resource Center utilized parent group sessions as a principle therapeutic intervention. Initially, the Center had only one therapist to provide services to parents and thus group therapy represented a practical and necessary intervention method. Groups consisted of primarily mothers with one father's group meeting for 10 months. The group disbanded due to the time demand on fathers to participate in other evening therapy sessions such as marital or family therapy. All four mother's groups continued to meet. The number of group members ranged from 4 to 10 parents.

The groups provided parents with a supportive environment thrcugh which he/she could relate to other parents who had similiar problems. Often this enabled the parents to realize that they were not the only parents to maltreat their children. Group therapy served as the first step for many parents.

Although the style and format of each group varied dependent upon the therapist and group membership, all groups focused upon the same goals: 1) increase problem solving skills, 2) build self-esteem, 3) increase awareness of self and one's relationship with his/her children, 4) reduce social isolation.

Parents have commented that groups helped them to "grow up", to accept responsibility. Members support and challenge each other. For some members the group is a primary social expereince. At times the need for a social experience had a negative outcome for individual members and the group as a whole. One group, composed of mostly young single mothers, prefaced each group session with a social hour. This social hour attitude became the norm and it became increasingly difficult to adjust to a therapy session. After much discussion, the group eliminated the social hour before group. However, several members continued to see each other outside the Center. For some members, this experience produced a positive outcome. For one parent, who was hospitalized, another provided for her child. For some parents, the expereince produced a negative outcome. Parents who began to "party together" found they could not share themselves, and could not meet each others needs. Often parents expressed suprise that their empathy and suggestions were helpful to another. Staff encouraged parents to provide feedback when appropriate.

Most parents graduated from group to participate in other family therapy sessions. Sometimes parents would attend group on an "as needed basis", if this was permissable under the group rules. Most groups permitted irregular attendance for a specific reason (e.g. a working schedule) but not for reasons of ambivalence or lack of investment.

Individual Therapy

Long term individual therapy was not extensively provided during the grant period. From a pratical viewpoint, the Center did not have staff available to provide the service. Parents assigned to individual therapy under three criterion: 1) the parent absolutely refuses to engage in group therapy, 2) the parent was experiencing severe depression or marital problems and as such her participation would be conterproductive for the

group, 3) transportation resources were limited and parent was not able to remain at the Center for a long period of time. In some cases, parent counselors were assigned to parents whose needs could not be met solely through group therapy and/or short term counseling.

Crisis Hotline

The purpose of the Hotline is to help parents learn to manage stress and crisis situations. Staffed by two Therapists, Project Director, and Children's Coordinator, 24 - hour coverage is provided. Parents are encouraged to call for help when they are upset so that they can verbalize their feelings, organize their thoughts, and formulate constructive plans. This service provides a constructive means of averting crises by offering immediate feedback to parents on how they perceive and plan to handle a situation. The telephone counseling appears to serve a secondary purpose of an ego-building device whereby parents are able to report success in handling their problems.

The volume of calls on the Hotline ranged from 0 to 15 per month. The average number of after-office hours calls were 7 per month. Beyond Hotline calls, parents often utilized parent counselors during crisis periods.

Although the vast majority of calls required supportive listening, some calls necessitated going to the family's home or initiating a emergency placement for a child and/or the mother.

Marital and Family Therapy

The purpose of this service was to: 1) access family dynamics, 2) intervene directly into the families interaction patterns.

Participation in marital and family therapy steadily increased over the three year period from three families in the first year to eighteen families in the third year. A total of thirty-four families participated in one or the other service.

Generally, this service was provided after a minimum of four months in the treatment program. Parents were reluctant to participate in family sessions. Some parents, primarily mothers did request the service. Although many fathers were unwilling initially to participate in therapy, the majority did actively engage. The principle variable affecting their participation was the therapist's approach. We were most successful when there was a direct outreach to the father and the therapist emphasizing his importance to the family session.

The involvement of children in the sessions was dependent upon the need of the couple to resolve marital issues. For most families, children were involved for at least a portion of each session. For others, children were involved on a bi-weekly basis. With school age children, the focus is was maintaining the family structure while enhancing each individual's ability to meet their needs inside and outside the family system. With younger children the focus was more often with teaching the parental unit specific techniques, they can use to manage their children's behavior.

This sometimes lead the couple into the expression of unresolved differences regarding child rearing attitudes and values. At this point, the couple was seen without the children to work on a resolution of these issues. The children were brought back into the sessions occassionally or may be seen in other treatment modalities in group or individual therapy.

Parent Counselors

This service provides mothers who are isolated and without resources a supportive friend. These parent counselors are available 24 hours a day to provide a trusting relationship, crisis intervention, and resource management. Parent Counselors are volunteers who are recruited, trained and supervised by the staff. Each must meet specific requirements regarding their childhood and parenting experience and ability to be compassinate, supportive, firm positive relationships. Parent Counselors are members of a treatment team serving as an adjuct to the therapy component.

Matched on the basis of neighborhood, social characteristics, and personality, the parent counselor is assigned to only one parent at a time. While counselors are in the role of a home visitor, they also engage in social activities with the parent such as: a lunch, shopping trips, a movie. In addition to providing socialization experience for parents, counselors have increased parents knowledge of child caring practices, improved problem solving skills, and provided parents with a unique friendship.

This service design differs from other comparable lay therapist models in that the frequency of contact and intensity of involvement are less than other programs. Generally, counselors have face to face contact about every ten days on the average and minimal weekly phone contacts. Most counselors had increased contacts during periods of crisis. These parent counselors are not reimbursed volunteers.

The parent counselor has developed a positive and therapeutic relationship for both parents and their counselors. Parents refer to their counselors with a sense of pride. They are astonished that anyone would sufficiently care about them as to visit, to help them without renumeration. Surprisingly enough out of 22 parent counselors involved in the program only 10% had sufficient difficulty as to leave the program. The bonds are strong between counselors and parents. Often after the counselors one year commitment, they do not accept re-assignment to another parent because of not wanting to start over with another parent. At times, Parent Counselors perform heroic tasks for their parents such as: storing an evicted mother's furniture, assuming care of a mother's children during a crisis period, finding employment etc. Parents and counselors often retain contact with each other even after formal ties are discontinued with the Center either in person or by mail if either has moved. Parent Counselors are a significant contribution to the treatment program.

MONDAY MORNING

GOALS OF GROUP MEMBERS

1) Friendship - The members want friendship, caring, and support from the other members of the group.

2) Good Talking - When a member of the group is presenting her ideas she wants to be able to:

a) Trust the group and "open up" to the group.

b) Present her ideas to the group in a way that others will understand her rather than laugh at her, etc.

c) Be honest, direct, and clear about her ideas - members want to be "straight" and "get down to business" when they are talking.

3) Good Listening - Each member wants to be a good listener by:

a) Really trying to "hear" the person who is talking and understand what is being said.

b) Not interrupting while someone else is presenting her ideas.

4) Helping - members of the group want to help others by:

a) Giving feedback that is honest but also shows caring.

b) Sometimes giving helpful pointers and suggestions.

5) Areas To Work On - Specific areas that members would like to work on include:

1) Coping with the kids.

2) Coping with tensions and feelings of grouchiness.

3) Relationships with men.

4) Getting houses in order and thinking of safety tips for the home.

5) Keeping our minds on tasks that we are doing.

BEHAVIOR MANAGEMENT COUNSELING (TRAINING)

Behavior Management Training is a counseling service that the Center implemented midway in the grant period. Originally, this component served parents whose children participated in the behavior management classroom. It became apparent that other parents could potentially benefit from the service. Therefore, the Center expanded this new service component for other parents.

Goals

The principal goal is to improve parent-child interaction patterns through:

1) Decreasing the use of physical and verbal punishment by parents.

2) Increasing positive statements from the parents about the child's behavior.

3) Expressing realistic age expectations of child's behavior on the part of the parents.

4) Reducing the frequency of identified problem behaviors as shown by chart data on parental report.

5) Decreasing parent reporting of new problem behaviors.

6) Increasing parent recognition of other salient factors as contributory to the abusive situation, i.e., personal, interpersonal, social, marital, etc.

Assumptions:

The basic theoretical paradigm of this componentis based on social learning principles (labeled synonymously) in the literature as "operant psychology", "behavior modification", "behavior therapy", or simply "learning theory". The general intervention sequence is: 1) specification of observable parent-child behaviors; 2) collection of pre-intervention baseline data to determine the rate of behaviors to be changed; 3) provision by the parent of positive consequences to increase desirable behaviors and negative or withdrawal of positive consequences to decrease undesirable behaviors; and 4) objective evaluation of intervention strategies by comparing baseline and treatment behavior rate data.

Population:

Parents who indicate problems in managing their children's behavior or are observed by staff are candidates for this service. Parents are selected for either individual or group training. Parents who met the following criteria were selected for group training;ability to follow directions for home assignments, participation in a class setting, willingness to attend

with no more than two misses, and agreement of both parents participation. Twenty-two parents participated in individual counseling. Fourteen parents participated in group training.

Description:

Individual counseling (training): The format of training involves office and home visits weekly. When the children are present the therapist models procedures and the parents practice with therapist feedback. When the children are absent the therapist will role play specific problem situations. In general, the therapist helps the parent to specify problem behaviors and verbally rehearse procedures to effectively manage behavior.

Group counseling (training): Two parent training classes have been conducted to determine the efficacy of providing parent training in groups. Specifically: Could more clients be served in a group setting? Will a group situation increase motivation and therefore enhance participation? Will parents develop supportive behaviors and helpful advice-giving with their peers? Could necessary changes in child and parent behaviors be accomplished? Goals for parents included: 1) demonstrated knowledge of child management principles and 2) identified changes in child behavior specified by parents.

The groups composed of 14 parents lasted seven and eight weeks, respectively. The sessions presented general principles with the hope that parents could generalize to new problem situations with a minimum of staff involvement. An annotated schedule is shown in Table 5. The two hour class schedule included: 1) brief lectures on specific topics with examples and response from parents elicited at regular intervals; 2) written exercises (see Table 6); 3) role playing/practicing of specific procedures; 4) application of principles to actual and exemplary problem behaviors; and 5) discussion of home assignments. Written summaries of key concepts and procedures were given to parents. Though principles were taught, the emphasis was on practice application of procedures. Home assignments included keeping a record on two targeted problem behaviors for one week (baseline) and implementing an intervention plan for behaviors which parents detailed in writing with the group leader. Parents continued to record behaviors during the intervention phase. Phone calls were made to remind the parents of these assignments. Concepts were detailed carefully with numerous illustrative examples.

Termination from this particular service occurs when 1) the parents indicate at least temporary satisfaction with the current situation, 2) the trainer perceives the parent is not willing to work on specific problems, or 3) other problems (marital or individual) take precedence over child management problems. Regardless of the reason for termination, most parents periodically request consultation around management problems.

Impact

Indicators of treatment effects include: 1) parent chart data (frequency primarily) on specific behaviors: 2) global parent reports of improvement (none-some-much) and 4) parents perception of their ability to manage their children.

TABLE 5

Family Resource Center

Parent Training Group

Suggested Course Outline: Annotated

First Meeting: Introductions - Overview - Forms.

General introductions between parents. Brief-over of the course is given: expectations)parents and group leader), content, format of class meetings, and home assignments. Several forms are filled out to get "baseline" on parents and kids: viguettes, referral problems checklist, behavior rating scale, and child management survey (these can be added to and deleted).

Second Meeting: Why Children Behave as They Do. Basic learning principles. Pinpointing Behaviors. Recording Behaviors.
Various explanations are given for why kids behave as they do (e.g.: bad infancy, bad genes, etc.) Suggested they behave to avoid punishment or receive positive consequences - because they have learned to behave as they do. This is seen as optimistic (compared to other theories) as they can learn and unlearn. The four basic principles of positive reinforcement, extinction, punishment, and negative reinforcement are explained with several examples and questions. For the parent (e.g.: "If I said 'thank you' to a child who followed a command I gave, which principle would be involved?").

Pinpointing or operationalizing target behaviors is explained. Parents do a written exercise to help them practice discriminating observable behaviors from vague descriptions. The importance of pinpointing is discussed.

Two basic recording methods are presented : frequency (how often) and duration (how long behavior lasts). A standard chart is hand-d out with a completed example (the parents will use this chart). Parents complete a written exercise on recording behaviors.

Third Meeting: Identifying reinforcers. Increasing appropriate behaviors. Setting goals.

A review, in the form of questions from the leader, is conducted around content presented last week. (Reviews precede each suceeding session)
An explanation is given of types of reinforcers (handout is also given to parents) and how to determine reinforcers for kids.
Parents give examples of reinforcers under types: (social, tangible, etc.)
Techniques for increasing appropriate behaviors are presented (with a handout): e.g.: shaping, positive reinforcement, modeling, contracting, and token economics.
Emphasis is on "catching the children being good." Specific instances of reinforceable behaviors are ellicited from parents in terms of their kids behavior.
Setting goals, in terms of small steps which insures successful performance, is presented.

Home Assignment: Baseline on 2 target behaviors

Fourth Meeting: *Decreasing inappropriate behaviors, developing a plan to help.*

Specific techniques which decrease inappropriate behaviors are presented with examples (time-out, response cost, extraction, etc.). A handout is given. Parents review the steps in changing behavior (Pinpointing - Baseline - Intervention - Evaluation). Specific problems are discussed and how they can be handled. Parent's baseline data is reviewed. Any problems with charting are discussed.
Parents are helped to develop an intervention plan for the two target behaviors charted.
They write their plan on the back of charts.
Home assignment: begin intervention and continue charting.

Fifth Meeting: *Rules. Evaluating plans to help. What to do if it's not working.*

A general presentation on rules is given (setting rules and enforcing them).
Evaluation of plans are discussed and several reasons are employed. For plans failing (e.g.: Failure to pinpoint, inconsistent consequation, inappropriate reinforcers used, etc.), parents intervention plans are reviewed and they either (1) continue as before, (2) revise their plan, or (3) place the child on intermittent schedule of reinforcement.
Home assignment: Continue or begin with modified plan of intervention.

Sixth Meeting: *Review. Parent Reports*

A "grand review" of the entire course is given.
Parents present their programs and explain what has happened with their children.

Seventh Meeting: *Closing. Forms*

Parents are offered telephone contact if additional problems occur which they find difficult to deal with. (In some instances an individual worker may need to go in the home to model and shape "skills" in the parents
Forms are filled out as in the first meeting.

TABLE 6

Pinpointing and Tracking Behaviors

Mark those target behaviors that are observable. Rephrase those behaviors which are not observable to make them observable.

1. Make bed without being asked.

2. Does not pick up her toys.

3. Feed the dog.

4. Child needs to be more friendly.

5. Be in bed by 8:30.

6. Child is bossy.

7. Stop fighting with brother.

8. Child does not like school.

9. Return home from school on time.

10. Cannot sit still.

Here are 5 behaviors which are fuzzy. Change fuzzy behavior to non-fuzzy behaviors;

1. Takes too long to eat.

2. Behaves poorly at school.

3. Is too messy.

4. Is too loud when he's in the store.

5. Does not mind.

Here are 5 target behaviors. In the blank before the behavior mark "F" if you think frequency is being counted. Mark "D" if duration is being counted.

_____ biting younger brother

_____ tantrums

_____ taking too long to eat supper (over 1/2 hour)

_____ does homework too fast so that it's sloppy

_____ runs out of yard

From the 5 behaviors above, chose 1 frequency behavior and 1 duration behavior and show how you would chart them.

Individual counseling: Due to the inconsistent parent recording of behavior, it is difficult to assess the effects of intervention strategies. For those parents who periodically record consistently there are indicators of desirable changes in child behaviors. In terms of global reports by parents, most indicate improvement in the children's behaviors. It is difficult to determine the validity of these reports. Social desirability and demand characteristics may certainly influence parent perceptions. It is also possible that parents are poor judges of the magnitude and frequency of their children's behavior. For example, some parents, when they actually recorded a behavior, they found it was not as bad as they had thought.

Group counseling: Parents involved in groups were more successful at charting behavior. Each parent specified and recorded at least two behaviors before and during intervention phases. At the end of each group, parents rated charted behaviors as mild or not a problem compared to initial levels. The chart date collected by parents indicated desired improvements with the expection of one other in the first group whose children continued to wet the bed three to five nights a week.

Global perceptions of positive improvement were indicated during and after group training. Most parents felt they were able to respond appropriately to problem behaviors.

In response to written questions (see Table7 class evaluation form), parents generally indicated at least moderate success in modifying behaviors of concern. In terms of their ability to handle future problems with their children, more often than not, parents felt moderately to very confident. Two parents in the first group felt less than moderately confident. Interestingly enough one of these two parents was quite successful in changing the two behaviors which percipated her involvement in the group. This family has now been terminated and recent reports are quite positive in terms of maintenance of behavior changes in her child. She also called to secure child management book references and has discussed principles and procedures with her child's preschool teacher.

One couple in the first group was an obvious treatment failure to the staff. Two weeks after the parent training group the mother was reported for abuse. This couple was not a typical case as the husband dropped out after two weeks and there were serious marital difficulties. In addition, one child in the family was exhibiting high rate disruptive behaviors and had a seizure disorder which was not being adequately controlled by medication. The family withdrew from treatment services completely within a few weeks.

In regard to the efficacy of training parents in group, we can document the following: 1) Ten parents or sets of parents can be managed by two therapists. 2) The group appears to increase motivation and enhance participation as parents chart behaviors more consistently and are more responsive to suggestions.

TABLE 7

PARENT TRAINING GROUP - CLASS EVALUATION

Date _____

Name of Parent _____

Children's Names _____

_____

This form is designed to give you a chance to evaluate the class. The information you give us will be very helpful in planning for future classes. Read each of the questions carefully, and give us your honest response. Thank you very much.

1. The class overall was: ___ very helpful ___ helpful ___ o.k., but not helpful ___ not at all helpful ___ hurt-confused more than helped

2. How would you change the class? _____

_____

_____

_____

3. What would you take out of the class sessions? _____

_____

4. What was most helpful about the class? _____

_____

_____

5. Below make a list of actual ideas from class you have used; and then, rate each according to how well it worked for you.

	Very Successful				Not Successful
a. _____	/	/	/	/	/
b. _____	/	/	/	/	/
c. _____	/	/	/	/	/
d. _____	/	/	/	/	/
e. _____	/	/	/	/	/

6. In terms of the target behavior I worked on in the class (which was _____ _____), it is now:

___ Not a problem
___ Mild problem - better
___ Just as bad as before
___ Worse than before

How are you handling this problem now? _____

_____

7. Additional problems which have come up or those you didn't deal with in class:

	Child	Problem Behavior
a.	_____	_____
b.	_____	_____
c.	_____	_____
d.	_____	_____

8. Please rate below, on the 5-point scale, how confident you feel in handling new problems as they arise:

I am not at all confident / / / / / very confident

9. Please rate below how successful you have felt yourself to be in this program:

I feel myself to be not successful / / / / / very successful

10. In group meetings I learned most from:

_____ the teacher _____ other parents

What I learned most in group was:

___ How to change my attitude about my child
___ How to change my behavior toward my child
___ Other, please explain _____

_____

11. I would recommend this class to other parents. ___Yes ___No

12. I think I would learn better to discipline my child with individual counseling help rather than in a class. ___Yes ___No

This may be a result of the screening process with the clients assigned to group. As with other group interventions with abusive parents, they seem relieved to find they are not the only ones with a particular problem and are supportive of other parents. Necessary child and parent behavior changes seem to be occurring with most families.

Impact Summary: Although indications have been generally positive, the nature of treatment indicators for this component makes for less than reliable conclusions. It has been necessary to rely on parent feedback in evaluating the training. Parent chart data is not independently checked, in fact, staff rarely views interaction sequences between parents and children. Global reports and written evaluations are subject to a host of validity problems.

Given these limitations we can with reasonable confidence make the following conclusions: 1) Parents who have an abuse problem are in need of specific training in child management skills. Deficits in these skills are not to be considered secondary goals. 2) Parents can substitute alternative management techniques with at least weekly professional consultation. Continuing assistance depends on the severity of child problems and parent ability and motivation. 3) For most parents involved in training the need for a home setting is indicated. 4) Most parents do not feel as helpless in dealing with their children. They indicate options are available which were elusive prior to behavior management counseling.

Given that only a handful of references in the literature could be found suggesting this approach with abusive parents, the efforts in this area have been exploratory and developmental in nature. This approach has not been adequately tested with abuse and neglect families. Our experience suggests modifications are necessary in applying this technology of parent training as it was designed for intact middle-class families where abuse is not a problem.

Issues and Recommendations

1. Intensity of involvement: It has been our experience that most parents lack the ability to apply general procedures learned from verbal and written instruction. The expectation that parents will read or hear about management techniques and apply them effectively is unrealistic. The disruption in abuse and neglect families compounds problems of application. Substituting less punitive and more positive techniques is a difficult task requiring motivational as well as conceptual prerequisites. Our best global estimate indicates about 10% of our agency population can effectively change child behaviors with the help of group training as described above (Tracey & Clark, Social Work, May, 1974; Jensen, J of Child Psychology, Spring, 1976; and Christophensen et. al., J of Pediatric Psychology, Spring 1976). These parents will probably need periodic follow-up contact (e.g. monthly for one year) to insure maintenance of changes and to discuss any additional problem behaviors which emerge.

About 35% of our population could benefit from group training with two or three days of in-home training with the children present. Once the parents have established base rates, the crucial period begins with the first three days of implementing an intervention plan. The therapist could go to the home during

this time to model and rehearse the planned procedures with the parents and children. This instruction increases the probability of correct performance by the parents and would also allow for staff to correct any mistakes and misconceptions. The mere presence of the therapist could serve to motivate parents. Again, periodic follow-up would be necessary.

The remaining 55% of our population would need more frequent intensive in-home training (e.g. Christophensen et. al., 1976). Understanding of general principles and procedures would be secondary to correct application of specific procedures. One or two staff could go into the home 2 to 5 hours a day, 3 to 7 times a week for a specified number of weeks until parents began to demonstrate some level of competency in managing their children. The staff could also be on call in case of an emergency situation. This would be a exhausting situation for staff. It would be advisable to assign only two families to one member. Another variation would involve staff going into the home at particular times when particular behaviors are more likely to occur (e.g. bedwetting at night).

To summarize it has become quite obvious to us that intensive in-home training has the greatest effective treatment potential for our population.

2. Staffing: We have found this behavior training promising and extremely frustrating (sometimes in the same week with the same family). The demands on the energy and motivation of staff are costly. Reinforcers for staff are costly. Reinforcers for staff in the form of rapid improvements in parents' management are sometimes difficult to obtain. The person responsible for this component should be well versed in operant parent training in addition to having necessary clinical skills. Staff can include students, regular staff personnel, and in some cases paraprofessional workers. Bi-weekly meetings with behavioral psychologist-consultants can be helpful in discussing cases.

3. Resistances: For whatever reason, some parents agree to carry out mutually developed therapist-client plans and some do not. Excuses range from "they forgot" to "something else came up that made the task impossible to carry out". For most parents, after working out a plan for the week (e.g. record behavior, implement change strategy, etc.), it is necessary to call at least twice in the week to remind them. We have provided self-addressed envelopes and postcards for parents to return chart data and other information. Every effort should be made to simplify procedures and to model and rehearse until parents demonstrate they can carry out plans correctly.

The assumption is that if parents know what to do, and see their children changing for the better, the motivation will be sufficient to continue with the plan. This has not always been the case. Some parents have refused more intensive in-home training. Some parents feel inadequate about their parenting skills and would be anxious about being viewed regularly. It is necessary to support parents, to emphasize and offer help, acknowledging that their children are exhibiting problems which would "bug" anyone. This is not psychological trickery. It is often the case with the children. Many parents resent being considered "different" because their children antagonize them. We believe it is important to be sensitive to parents' feelings.

With some parents, failure to apply management procedures may indicate other problems (financial, marital, etc.) are taking precedence. These must be addressed before parents can devote sufficient attention to child management problems. Offering behavior management counseling in isolation is not sufficient for most families.

At times it becomes necessary to temporarily terminate some parents if they choose not to work. This can be done with the idea that the parent can re-institute the service when they are ready. We have found that when parents consistently neglect to perform some weekly task (e.g. charting) with several weekly reminders, it is unlikely they will attempt to change in their responses to their children.

4. Parent Reinforcers: We have assumed that parents will be reinforced for changing their patterns of responding when they begin to see positive changes in their children; i.e. a mutually reinforcing relationship between parent and child will develop. At several junctures we have been forced to question this assumption. It is apparent this is not enough for some parents. It may be advantageous to use existing services (e.g. child care, social outings, babysitting, or to pay parents) as contingent reinforcers for parent cooperation in carrying out therapeutic plans. On a smaller scale we have made social charts and telephone calls with staff contingent on parent cooperation with no adverse effects. For example, on a home visit we require parents to "work" the first 45 minutes (discuss problems with the kids, detail intervention plans, etc.) and then we will talk about any topic with them. This procedure has helped to keep parents on task with no overt negative reaction to the staff members.

5. Outcome Measures: As discussed previously, this area has been slow to develop. Parent chart data can be used with its obvious reliability and validity problems. A potentially more useful measure would be direct observational data collection in the home (e.g. Patterson et. al., 1975). Problems of reliability reactivity, internal and external validity need to be assessed. Pre-post behavior-rating scales (e.g. Walker Problem Identification Checklist, Devereax Elementary School Behavior Rating Scale) can also be useful for children over 7 years. Attitudinal parent-child measures may be of theoretical import but would not identify discrete behavioral changes.

Summary

It is important to remember that the goal is not to make problem-free "superparents" but to substitute some potentially and actually harmful discipline techniques. Changes will be slow and in small steps. The behavior management component has been greatly expanded and developed because our parents have indicated a need for this service. We believe it has potential and is a viable treatment option for any agency working with abuse and neglect families. Although it seems we have learned more about what not to do, we consider this valuable information if it is used to make necessary changes. Flexibility in light of parent responses to treatment must remain the hallmark of this approach.

Recreational Therapy

During the grant period, the Center's staff instituted three types of recreational programing for parents and children. They included: family/staff social functions, craft and outing sessions, and children's summer program.

Family and Staff Social Events: Social events are scheduled on a semi-annual basis. Generally, these events are Christmas parties and summer picnics. A joint committee of parents and staff coordinate food, location, and activities. At the first two events, parents voted not to have their children participate identifying the need to "be away from the kids". On subsequent events, parents voted to have the family together.

The staff view these events as therapeutic in that it provides a social interaction time for families, reduces isolation, and involves families in new social experiences. An unplanned outcome is that some parents have experienced acquired new skills in planning activities, recruiting volunteers, and meal preparation. Approximately 60% of all families attend the events.

Craft Activities: The purpose of this activity was to provide a environment for positive social interaction and building self-esteem. At craft sessions parents began "to play" and to engage in activities not previously experienced. Parents would often verbalize "I can't make this". After some coaxing parents would attempt to complete an item. Parents were often astonished at their own achievements. Some parents brought projects for group to make, many would make items for their children. This group met for about a year. Due to a lack of time and money, the group converted into a "social outing group". Social outings were conducted every two months to various community attractions. For many mothers this was there first opportunity to visit such places. Many expressed the desire to return with their families. Some parents actually did return.

Children's Summer Recreational Program: Each summer the Center's professional and volunteer staff have conducted a 10 week recreational program for boys and girls. The children ranged in age from five to eleven. The purpose of the program was to provide a positive social and enriching experience for the children. Both abused children and their sibs were involved. Approximately 18 children participated in the program. The weekly three hour activities were structured activities. These included: group activities (baseball, kickball, etc.), community attractions (museum, zoo, etc.), and individual activities (swimming, bike riding, etc.). Special activities included: over night camping trips and a six week art class at the museum. No suprisingly enough, some of the children had never swam in a river and expereinced great difficulty in understanding the flow of water.

We have found the summer program to have positive impact upon the children fostering the development of positive relationships with peers and adults and building self-esteem in attaining new skills. However, we have also found that arrangements with parents for permission forms, transportation, and weekly activities have required considerable expenditure of time.

Case Management

Case management involved both the external and internal coordination of cases. In both areas, the management required an extensive and intensive concentration of personnel in order to design and maintain effective case coordination.

Externally, it was not uncommon for two or three agencies to be involved with a family at the point of referral to FRC. Principally these agencies were the Division of Family Services, Juvenile Court, and a hospital. Often it was unclear as to which agency was providing which service and which agency was coordinating the case. There was no formal accountability mechanism. The project was a private voluntary agency and consequently had no legal mandate to sanction or coordinate the case. However, in most cases it was the principal treatment agent. The result was that in each case the degree of coordination was dependent upon the combination of various agency workers: and as there was a large number of these worker combinations, there were varying degrees of effective case management.

Usually, communications were channeled through the DFS protective service worker. However, this was an informal understanding among agencies and was not particularily effective. FRC and DFS did have a formalized agreement which was basically ineffective. At the end of the grant period, DFS formally defined the role of the protective service worker. DFS adopted a Multidisciplinary Approach format with the protective service worker defined as the Case Manager. This role restructures the role of the Protective Service worker and advocates the purchase of community services. This role definition has provided some improvement.

We have found that the developing and maintaining of an effective communication network among the public service agencues to be a primary goal but not necessarily an attainable one. The reasons are varied. First, the four primary public agencies, Division of Family Services, Division of Children's Services (the foster care agency), Juvenile Court, and the police do not have established communication lines. This is demonstrated in both the administrations' and workers' lack of knowledge regarding each agency's policies and procedures. There are no mechanisms established to resolve case conflicts and to monitor cases. Secondly, the frequent staff turnover precludes developing a systematic approach with the agency. Therefore, communications must be constant - informing new workers and even old ones. Third, there is no centralized

The internal management of cases involved several areas: 1) a record system, 2) systematic review of cases, 3) communication with team members.

The major factors affecting the design of a client record system was how to consolidate the relavent information on all family members and be available to all appropriate staff persons. After explaining several designs, staff determined that the sheer volume of the files preluded the consolidation of adult and child forms. Therefore, child program

forms (including testing data) were separated from the family's service record. Progress notes and attendance records on children were maintained. The system did not provide a totally satisfactory method for collecting and distributing information.

The method of reveiwing case progress consisted of quarterly staffings, written summaries, and family conferences. At the quarterly staffing, written reports sumarizing the family's treatment plan and proposed were presented by the therapists/teacher involved with the family. The family conferences were designed for the purpose of staff and family members to review progress to set goals. The conference also supplied a written summary for the family. Only about a third of the families routinely participated in the conferences. For those families, the parents acknowledged the value of the confernece sessions particularly citing the fact that " it felt good to hear they were changing".

Communications regarding cases among team members were lossely structured. Staff tended to rely on oral communications versus formal case notes. For a time period when both staff and case size were low, this method sufficed. However, with client expansion it became apparent that more formalized case records were necessary. By large staff resisted efforts to change written record procedures as it meant an additional time burden whose value was not universally accepted.

Client Termination Process

The termination is a gradual process lasting from 3 to 6 months during which the family as a unit reduces the number of services. For example, a mother who is in group therapy and has also become involved in marital counseling or behavior managment counseling, may choose to reduce he participation in group therapy. She may attend only once a month or when she feels she needs additional support.

This gradual reduction in services to the family corresponds to an increase in acknowledgement of the family's strength and ability to solve its problems and to support and sustain each other. For some families, the level of involvement and dependence has become sufficiently extensive and intensive to make it difficult for them to view initial discussions of termination as positive indicators of growth. Parents sometimes feel rejected and temporary reversion to problematic behaviors of the past are not uncommon. However, with continued assurances by the staff that the family is doing well and that help from the Center is only a phone-call away, families begin to accept and to benefit from the termination process. On the suggestion of a parent, FRC now identifies termination as "graduation" for parents as well as for children.

The last step in the family's "graduation" process is a family conference, in which therapists, parents and children summarize their experiences and reaffirm their goals as a family unit. Parents are invited to participate in their children's last day in the classroom in order to share in the festivities and to learn projects for home use.

Graduation is not a final separation for FRC families. FRC staff encourage parents to call in case of need, or simply to share family events. Calls from parents have occurred. Five parents have returned to the Center for short term counseling around a specific problem a crisis situation.

Finally, graduated parents are invited to the Center's social events. Although only a few actually attend, we believe the invitation serves as a reminder that the Center is "a phone call-away".

RE-INCIDENCE OF ABUSE/NEGLECT

The number of families in treatment shows a steady but gradual decline throughout the first year of treatment. Sixty-four percent (41) of the families are in treatment for six months while 30% (19) remained in treatment for twelve months.

Table 8 shows the number of families which had incidence of maltreatment during each month they were in treatment. Both physical abuse and physical neglect decrease sharply as families receive treatment. Forty-eight percent of the families had an abuse incident in the first month compared to 20% in the second month of treatment. Between 8 and 19 months of treatment an average of 8% of the families had any occurrance of abuse. Only 12 families (19%) had an occurrance of neglect during the first month. By the second month, the number of families with an incidence of neglect dropped to 8% (5), and remained fairly constant through 19 months of treatment. The few families who remained in treatment longer than 19 months had no incidence of physical abuse or neglect.

The pattern of response to treatment is different for abusive and neglectful families. Eight of the 12 families who had a incident of neglect while in treatment continued to neglect their children until treatment was discontinued. If physical abuse accompanied the neglect, the abuse also tended to continue throughout treatment. Physical abuse did not exhibit the same trend. Thirteen (28%) out of 46 families had an incidence of abuse within two months before they were terminated and seven of these families were ones in which abuse and negelct were combined.

In contrast to physical abuse/neglect, the percentage of families with an incidence of emotional maltreatment does not show a sharp decline in occurrance. Instead, the data resembles a sine function that begins with 59% in the first month,drops to 33% by the 10th month, rises to 69% in the 16th month and falls back to 38% in the 18th month. Whatever the cause of the fluctuations, it seems clear that emotional maltreatment is more resistant to therapeutic intervention than are physical abuse/neglect.

TABLE 8

NUMBER OF FAMILIES WITH OCCURANCE OF PHYSICAL AND EMOTIONAL MALTREATMENT[1]

Type of Maltreatment[2]	Months of Treatment																							
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Physical Abuse	31	12	10	9	12	8	7	2	3	2	2		2	2	1		1	1	1					
Physical Neglect	12	5	5	3	4	2	2	2	2	2	2	3	1	1	1	1	1	1	1					
Emotional Maltreatment	38	29	23	19	19	16	14	10	9	8	8	10	6	7	7	9	8	5	5	4	3	3	3	1
No. of Families in Treatment	64	59	54	50	46	41	35	29	26	23	21	19	15	14	14	13	13	13	13	11	9	8	6	3

1. Includes families starting treatment between Dec. 1974 - Dec. 1976.
2. Includes maltreatment of any degree of severity.

Transportation

Transportation service was provided for both children and parents attending sessions at the Center. The preschool programs transported the children to and from the Center daily. Midway through the project a van was purchased and a driver was hired to provide the transportation. Prior to that time transportation was provided by the teaching staff in their cars or other staff cars. Those parents who had access to cars were urged to transport their children. In effect, only two parents were able to do so.

Parents were transported in the van with the children. Otherwise parents were provided vouchers to use a commercial taxi to come to the Center. Parents were encouraged to car pool, to take buses, and to locate whatever other sources may be available. Some parents did; most parents did not. Providing an easy transportation system appeared to be the only method of assuring parent's attendance.

Transportation can be described as a necessary service for any agency program servicing abuse/neglectful families. However, the expense of time, staff, and financial resources necessary to provide this service may be prohibitive for most agencies. In addition to the cost of the van, driver, maintenance, fuel, and insurance, a tremendous amount of staff time is expended in coordinating route changes, supervising the driver on safety and the appropriate use of behavioral intervention with preschool children, compensating for driver illness and van down-time and rescheduling due to parent changes.

Child Enrichment

Initially, the purpose of this service was to offer an incentive for parents to attend therapy services at the Center. By providing supervised sessions for their children, parents would not have to pay for or seek out a babysitter. In addition, parents would not be able to use the children as an excuse for not attending therapy. In effect, parents have reported that the childcare was an incentive for them. An additional function of these services was the opportunity to observe behavior, skills, and social interaction of the target children and their siblings.

This service began as a "babysitting session", however, through efforts of the Children's Coordinator and the volunteers; the service format evolved into a structured child enrichment program.

Children, from birth through eleven, participated in four two-hour sessions weekly with approximately 26 children being served per week. Two rotating volunteers provided positive group experience through guided social interactions. The schedule of activities include: arts and crafts, gross motor, songs, games, and snacks. Children expressed an eagerness to participate in the program, often asking when arriving at the

Center whether their friends will be there. Most children who were fearful, anxious, and unwilling to separate from their parents began to participate actively in the program after a short period of time.

Although we have found the child enrichment program to be beneficial for parents and their children, several considerations should be made in providing this service: 1) Although this service can be staffed by volunteers, it is esential that a professional staff person be assigned to provide initial and in-service training, on-going supervision, and support for volunteers 2) Maintaining a volunteer service requires extensive scheduling and back-ups during holiday and vacation periods. 3) The sessions must contain structured activities and a consistent use of behavioral limits for the children. Without these, the results can be disastrous - the extreme being chaos for the children and the volunteer. 4) Of all volunteer positions at the Center the child care volunteer has the shortest average length of staff - - four months. The position requires sensitive, patient, and committed volunteers.

Play Therapy

There were three objectives for providing play therapy:

1. To assess the child's social-emotional development
2. To develop, improve, and/or increase the child's ability to express feelings and needs.
3. To teach the child effective means of communicating, problem solving, and relating to parents, siblings, and others.

Children were selected for play therapy because they demonstrated extreme anxiety, social withdrawal, inappropriate aggression, pervasive sadness, poor impulse control or are having unusual adjustment problems at school. Other children were selected because crisis situations in the home affected their well being. Children ranged in age from three to ten years with the majority of children being six to eight years old. Eighteen children participated in this service.

Children were seen once a week in sessions varying from one-half hour to an hour. They were provided an assortment of materials to work with as means of expressing feelings. These include: puppets, dolls, dollhouses, dressup clothes, guns, soldiers, punching bag, bean bags, crayons, paints, clay, etc. The children used these materials in expressing a wide variety of feelings (fear, anger, conflict, anxiety, pain, frustration, guilt, joy, excitement, wishes, rejection, denial, power struggles, etc.).

Many of the children in play therapy have developed and/or increased their ability to appropriately express feelings and needs. This is a gradual process beginning when the therapist labels the feelings a child is expressing through play. In time the child verbalizes this to the therapist. Some children have then demonstrated the ability to do this with parents (eg. instead of throwing a temper tantrum a child will say, "I'm angry Mommy because of ..."). This is reported by parents and also observed in family therapy sessions. Problem solving techniques and alternative behaviors in special situations are learned in play therapy. This is being accomplished through discussion, modeling and role-playing. Some children then are able to verbalize awareness of their own behavior and how it effects family conflict.

TABLE 9

ANNUAL DISTRIBUTION OF CHILDREN'S SERVICES

MAY 1974 thru FEBRUARY 1977

SERVICE	Unit of Measurement	MAY 1974 - FEB 1975	MAR 1975 - FEB 1976	MAR 1976 - April 1977	TOTAL
Behavior Classroom	children/sessions	n/a	71	229	300
Child Care	children/sessions	19	144	227	390
Counseling	children/sessions	6	0	0	6
Development Classroom	children/sessions	70	243	273	586
Diagnostic Screening	children/sessions	16	29	22	67
Group Therapy	children/sessions	n/a	n/a	35	35
Pediatric Consultation	children/sessions	4	14	6	24
Play Therapy	children/sessions	29	72	76	177
Psychiatric Consultation	children/sessions	4	10	10	24
Psychological Consultation	children/sessions	0	22	23	45
Psychological Testing	children/tests	12	82	276	370
Referrals Made by FRC	children/	4	13	24	41
Speech/Hearing/Vision Evaluations	children/sessions	5	12	35	52
Transportation	children/trips	140	614	1,763	2,517
Total		309	1,326	2,999	4,634

DIAGNOSTICS

Goals

The goals of this component are identical to those listed in the report on project year two. They are administering diagnostic tests to abused/neglected children to: 1) determine the need for educational interventions, 2) evaluate treatment services for children, 3) provide information for referral to schools and medical agencies, and 4) contribute to the research literature on abused preschoolers.

Population

We have almost exclusively tested preschool age children with 81% of all children tested under age five. This specific focus resulted from the pre-school classrooms the Center provided as well as the greater accessibility of this age group. During the funding period, we screened 68 children from 52 families. Forty-eight of the children were targets of physical or emotional abuse, while the remaining 20 children were either sibs of the abused child or potential abuse cases.

Description

A trained diagnostic teacher conducted diagnostic screenings to all abused children referred by the intake worker and/or parent therapist. The initial screening tests included: 1) Denver Developmental Screening Test, 2) Peabody Picture Vocabulary, and the 3) Vineland Scale of Social Maturity (administered to the parent). In addition, the Diagnostician scheduled two sessions with the parent. The first session collected information regarding the child's developmental and family history. The second session involved explaining the test results to the parent and making a recommendation regarding specific intervention strategies or placement for the child.

Once admitted to either pre-school classroom (developmental-remedial, or behavior management), the diagnostician administered several additional tests.
(for a complete list of test administered, see appendix).

The test are administered approximately four to six weeks after the child's admission to the classroom. This delay offered the child necessary time to adapt to the environment and the teaching staff.

The diagnostician administered the second round of testing six months after the child's entering into the program. Children received a final battery of tests at termination (see the Research Section for a description of the Psychometric Properties of the tests).

Impact

Results of the screening tests indicate a disproportionate number of children who may have developmental delays. Out of 55 children, 11 were

scored abnormal on the Denver Developmental Screening Test (DDST). Twenty-four percent of the target children were abnormal on the DDST compared with 12 percent of the non-abused children. On the Peabody Picture Vocabulary Test the results were, again, lower than would be expected. The 61 children had a mean IQ of 83.4, a score slightly more than one standard deviation below the normed mean. In terms of practical imput the testing has allowed us to screen for developmental delays and to determine general intervention priorities for children admitted to one of the classrooms. Referral agencies have expressed positive feedback for diagnostic information provided by the Center. It has helped them to determine more appropriate diagnostic procedures, intervention strategies, and placement for children referred for neurological, speech, learning, and language problems.

Recommendations

1) Diagnostic Services: We have found the diagnostic services to be of value for intervention and evaluative purposes. These services do require an experienced tester who can overcome the hesitancy and resistance to testing demonstrated by some of these children.

2) Instruments: Although an effort has been made to select appropriate and psychometrically sound assessment devices, there are few such measures for preschool children. Test were selected on the basis of program utility and the relative adequacy of their standardized procedures. Diagnostic personnel should review tests to be used and be able to interpet them in regard to limitations specified in the literature.

In terms of educational therapeutic programming, it is important to have informal developmental checklists which pinpoint specific skill deficits requiring remediation (e.g. the Portage Project Checklist and Alpen-Boll Developmental Profile). IQ scores and even standardized scores in a variety of areas do not help teachers to know what specific skills each child must be taught. (See Appendix I for tests administered).

3) Utility: As mentioned before, testing has served several functions in the agency. It has been and remains a policy of the agency not to assign diagnostic labels (e.g. mentally retarded) to children unless it is necessary to secure appropriate services. The emphasis is on determining a child's current functioning to enable the staff to develop individualized educational programs. The major purpose of assessment is to determine where a child is, where we want him/her to go, and how we can bring the child there. If staff responsible for educational therapeutic interventions respond with "so what!" after viewing diagnostic findings, then the staff should reassess their efforts.

4) Observational Records: It has become increasingly clear that direct observational recording of social behaviors is necessary. There are few social-behavior measures for preschool children with the exception of teacher rated checklists (e.g. Preschool Behavior Questionnaire). The staff began recording the frequency and/or duration information on pin-pointed behaviors (e.g. hitting others). As recording continues during an intervention phase, a determination of the effectiveness of the intervention can be made by comparing with the initial base rates. Informal recording can be done easily on one child. Time sampling with predetermined behavioral categories can be done on several children. Staff members can be freed from duties to make this observation only if time is available to train observers.

Training of staff will demand varying amounts of time and effort depending on the sophistication of the recording procedure called for. *

5) Reactivity of Test Situation: Consistent with the experience of others (Martin), we have found many of the children difficult to test. This has taken generally two forms: Some children are extremely oppositional and, at times aggressive. They refuse to follow directions, run around, throw things and strike out at the examiner. If a child will be or is in one of the classrooms, then we will respond with a brief time-out procedure. The child is placed in a chair facing a corner. When the child is quiet he/she returns to the test. For children who refuse to respond we wait them out. We have found this effective as the child is desirous of re-entering the classroom setting. With this type of child, the first test session is tumultuous although succeeding sessions are much easier for both child and examiners. We think this would not be the case if limits were not set and enforced. The other general form of reactivity involves children who are withdrawn and unresponsive. With this type of child several short test sessions may be given to reduce their anxieties. If a child is being seen for the first time, the parent may be allowed to accompany the child. However, the session should be terminated if the parent becomes upset about the child's lack of responsiveness. Generally, withdrawn children will respond consistently after two or three sessions. With either form of reactivity the use of edible (raisins, etc.) and activity (blocks, crayons, etc.) reinforcers has proven effective in motivating children to respond.

Test results obtained under the above conditions should be interpeted with extreme caution. Any deviation from standardized test instructions should be noted. It may be necessary to "throw out" some test scores. Children's reaction to test demands can be of diagnostic significance. Important implications can be learned about how the child is likely to respond in a structured school setting. This knowledge is also important in terms of educational therapeutic plans for the child.

6) Follow-Up: A particularly difficult task has been the completion of one year follow-up tests. This is a time consuming process as permission form school personnel and parents must be obtained. Most often arrangements for testing must be made after school hours. In addition, time must be found to interview school teachers or agency personnel presently involved with the child. Quite often these people rightly expect feedback and recommendations. For these reasons it may be helpful to contract for follow-up testing with some outside agency or the school itself.

* For references see: Sheppard, W. C. et. al Teaching social behavior to young children.

The initial grant design proposed a therapeutic day care program for abused and neglected children. For several reasons, the day care program was revised to consist of a remedial classroom for developmentally delayed children and a behavior management classroom for behavior problem children. First, the specific needs of the children necessitate different classroom programs. Second, we believe that two programs would serve a larger population. Third, the Family Resource Center facility would require extensive renovation to comply with licensing requirements.

Goals:

The goals of the program have been elaborated over the three years but have not changed substantially. They are:

1. To increase the abused child's ability to function in a community day care program or public school kindergarten by providing him/her with a structured, therapeutic, and educational environment which will a) assist the child in acquiring age-appropriate developmental competencies such as language and fine motor skills b) facilitate the development of a positive self image - and a sense of autonomy.

2. To facilitate the development of positive social interaction among the children and adults.

3. To reduce the potential for parental abuse by decreasing the children's problematic behaviors and developmental lags.

4. To provide training to students in preschool classroom teaching skills with abused children.

Population:

The type of children enrolled has been fairly consistent over the three years: three to five year old children exhibiting developmental lags primarily in language, motor, and social areas. There are currently eight children in the class, and a total of eighteen children have been served in this class over the past three years. Of the eighteen children, fifteen (83%) were targets of some type of abuse/neglect. Ten children had been physically abused and five were physically neglected. In addition, ten children were both emotionally abused and neglected. Three of the children had been placed outside of the home for some period of time due to abuse. Some of the children have special characteristics thought to be associated with abuse. There is one set of twins. Three children have physical disabilities in the form of known seizure disorders. Three children had no understandable language when they first entered the program even though they were at least three years old, while two other children had severe articulation problems requiring speech therapy.

The children in the morning class are from 14 different families. The families have an average of two children. Eight families are ADC recipients. Of the fathers in the home, most have high school education; in contrast,

the mothers are almost equally divided between having either partial-college or high school education and high school. Almost all of the father's are employed full time, while most of the mothers are unemployed.

Child Characteristics: We have observed some common behaviors of the children at the time of intake: 1) Most children have exhibited a bland affect, showing little or no facial expression or feelings at appropriate times (smiles, anger, excitement). 2) Most children appeared to be fearful. Sudden movements made by teachers or other children often startled them and they reacted with fearful watchfulness and anxiety. 3) The children demonstrated inappropriate responses to adults. Behaviors ranged from running to strangers and hugging them to crying if approached or spoken to by a teacher. 4) Most children demonstrated minimal language skills, speaking in one or two word sentences. 5) All children demonstrated an inability to play with or speak to other children. Many would quietly watch another child take a toy away from them and make no move to protest. 6) Children were unable to make wants and needs known. Most children did not communicate, even non-verbally, in order to ask for food, bathroom, toys, etc., until this skill was taught to them by staff.

Initial Test Results

Initial test results for morning children are presented in Tables 10 through 13. *As would be expected, only 33% of the children were scored as being normal on the Denver Developmental Screening Test (DDST). Results on the two IQ tests are similar. The mean score on the Peabody Picture Vocabulary Test was 69, while the mean score on the General Cognitive Index of the McCarthy Scales (MCSCA) was 78. Results from the Preschool Behavior Questionnaire showed that 61% of the children exhibited behavior indicative of emotional disturbance with anxiety being the most prevalent problem.

Although both the PPVT and MCSCA scores are over one standard deviation below the normed means, the nine point difference between the two scores is interesting. Because many of the children couldn't be tested on the McCarthy until they had been in the program for several months and because the McCarthy is the last test given, the discrepancy is probably represents both motivational changes and program induced learning. **

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* Intertest correlations are discussed in the section on psychometric properties of the test.

** The mean age at time of testing was 36 months for the PPVT and 43.5 months for the MCSA.

Table 10

Initial Peabody Picture Vocabulary Test IQ

	Morning Classroom
$\bar{X}$	69.44
Median	70.50
Range	50-85
Total N	18

Table 11

Initial Denver Developmental Screening Test

	Morning Classroom
Normal	33%
Questionable	17%
Abnormal	50%
Total N	18

Table 12

Initial Preschool Behavior Questionnaire:
Percent of Children Ranked Above 90th Percentile

	Morning Classroom
Total Questionnaire	61%
Subscales	
Hostile	50%
Anxious	72%
Hyperactive	39%
Total N	18

Table 13

Initial McCarthy Scales of Children's Abilities
General Cognitive Index

	Morning Classroom
$\bar{X}$	78.13
Median	81.00
Range	50-107
N	15

Criteria for Services

In keeping with the objectives of the program, abuse/neglected children admitted to this program are between the ages of 2½ - 5 years old and have development delays in one or more areas. The reasons for these criteria are two-fold: 1) We do not presently have the facilities to care for younger children, and 2) there are few resources for developmentally delayed preschool children in our geographic area. There are two other factors which restrict the children we can serve. Because we feel that both the parents and the children need help, at least one parent must be receiving services from this agency. A logistic but not trivial limitation is that either the child must live within our driving route or the parent must be willing to provide transportation.

Progran Description

This program has undergone several expansion changes over the three project years. It began as a loosely structured program emphasizing a safe and warm environment for abused children with little emphasis on remedial skill teaching in actual operation. Partially because of the orientation of new staff and primarily because of the obvious developmental needs of the children, it became necessary to change the structure of the program. Specification of objectives and direct teaching of dificient skills resulted in a moderately structured remedial program. The classroom enviornment remains "warm" and "safe" with the added remedial orientation. We found it possible to create a classroom environment that was conducive to emotional and cognitive growth.

Classroom Schedule

The classroom schedule is shown in Table 14. Each of the program components and its rationale will be discussed in detail below.

In addition to insuring that the children are provided with and learn about nutritious food, the purpose of breakfast is to provide informal practice in language use and social interaction.

During fine motor time the children are offered a choice between using the fine motor equipment and taking part in the teacher directed activity. The primary purpose of the fine motor choice is to develop eye-hand coordination.

The purpose of the teacher directed activities is to meet a specifically planned goal and to develop the ability to listen and to follow directions. The activities are chosen from one of the following areas: language science, math, ecology, sensory-tactile or practical-life experience, depending on the focus of the week. Many times the teacher directed activity will be coordinated with the next activity - art. During the teacher directed art activity the primary focus is either skill oriented (eg; making collages, finger painting). Art time is also used to reinforce a concept that is being taught that week or that day such as pasting on facial features when learning the parts of the body. When the children finish the art activity they are free to choose from sandbox, easel, or water play.

The primary purpose of story time is to develop listening and language skills. The story the teacher reads often illustrates a concept or idea

TABLE 14

SCHEDULE FOR DEVELOPMENTAL REMEDIAL CLASSROOM **

8:30 - 9:00	Staff arrives sets up rooms, prepares breakfast
9:00 - 9:30	Children arrive - health checks - breakfast - clean-up
9:30 - 9:55	Fine motor activity directed by teacher based on child-selected instruments
9:55 - 10:30	Two arts and crafts activities - one directed by teacher and one child-selected
10:30 - 10:45	Story time
10:45 - 11;00	Snack time
11:00 - 11:15	Group time - concept learning or large motor activities
11:15 - 11:45	Free play
11:45 - 12:00	Preparation for departure

** Outdoor activities occur between 10:30 and 11:00 and field trips depart at 9:30. Prescription times are held at fifteen minute intervals between 9:30 and 10:45.

currently being taught. After the teacher reads a story, the children choose a book to look at themselves. This is a time when the children often seek out some adult attention and affection.

Group time is a structured, teacher-directed time to teach language and cognitive concepts such as opposites, verbs, colors and shapes, spacial concepts and body awareness. This group learning experience provides children with an exposure to some of the techniques and expectations that they will later encounter in school. Group time is also used to teach student teachers sequencing and group teaching skills.

During free play the primary focus is on developing positive social interactions with peers. Along with the free choice times during the reading and art periods, this activity is also used to assess and encourage the children's abilities to engage in self-directed activity. The children choose any of the play areas, house keeping, blocks, puzzles and games, or dramatic play. The teacher's role is to facilitate positive peer interaction using positive reinforcement. Recently we have been using reflective feedback or active listening as another tool to encourage interaction. These techniques may also be useful in developing adequate communication skills.

During the song time the children learn songs and finger plays. The purpose is to develop memory, rhythm, coordination and skill in listening and following directions. The session is ended with the same song every day to give a clear ending signal.

In addition to the regularly scheduled activities, we periodically take the children on walks and longer trips may be connected to some ideas being taught in the classroom, or they may be to expose the children to activities and settings provided by the community. The playground we use is a block and a half down the street. This walk is helpful in reinforcing safety rules and in developing an awareness of community workers and ethnic variety.

Terminal Objectives

A terminal objective defines the performance expected of the child when he or she reaches the activity's goal. Terminal objectives serve as starting points for determining the skill hierarchy. The procedure is to begin with the compentency or skill expected to be mastered and work backwards, carefully analyzing what the learner must be able to do before he or she can perform the terminal objective (see Table and for examples). It is the system that is used to ascertain the child's entry behavior (which refers to what he can do now) and to plan the steps necessary to assist him or her in mastering a designated skill or concept. These objectives are written for all areas of the classroom and define what skills a child should demonstrate before he/she leaves the program.

Activities for each child include developing discrete motor, language, and cognitive skills which are either absent or emerging. The approach used is similar to the task analysis model as described by Ysseldyke and Salvia (1974). Evaluation of this model involves pinpointing where a child is

functioning competently. Complex skills are broken into component parts to insure that the child experiences success while acquiring new competencies.

Prescriptive Format

Descriptions of the prescriptive teaching approach in the literature contain several essential elements: the use of diagnostic information in educational programming, the provision of individualized teaching activities tailored to the child's specific deficits, and ongoing evaluation of the child's progress. The adaptation of this approach includes these essential elements.

The prescriptive modulars occur in 15 minute segments for the first hour in the morning schedule following breakfast. Children are taught alone or in groups of two or three if more than one of them has a common skill deficiency. Three skill areas are specifically focused on during the prescription modulars: language, motor, and cognition. Weekly or bi-weekly prescriptions are written for each child focusing on his/her specific deficiencies. The prescription form utilized specifies the skill area, the behaviors the child is to exhibit, the procedures to teach these behaviors and performance criteria from which to evaluate the child's progress. The child receives skill instruction 15 minutes each day; at the end of the week the prescription is marked achieved, carried over to the next week, or is broken down into smaller prerequisite subskills so the child can achieve success. Space on the prescription form allows for daily monitoring of the child's progress by use of simple code: I = skill development in progress; A = Achieved; NP = needs prerequsites, or FR = further reinforcement of skill needed. As can be readily deduces, the emphasis is on specificity and proper sequencing of tasks to allow for high rate of success, (as these children need no additional stress). In addition to promoting skill development, the prescriptions serve as effective diagnostic tools regarding the child's approach to tasks, individual learning styles, reactions to frustration, and level of motivation.

Every 3 months the Portage checklist is brought up to date and new prescriptive goals are written for the following three months. Prescription goals are written on the Prescription Goals Record form (See Appendix) to provide a summary of each child's progress. Along with the Prescriptions Goals Record form, each individual prescription form marked achieved is placed in the child's booklet. Prescription goals achieved are reviewed periodically and incorporated into other prescriptions to insure retention (e.g.; If a child has learned to identify pictures depicting some action he/she on another prescription would be required to identify and label those same action pictures).

Teaching Techniques

As was pointed out above, techniques used in prescriptive programming are derived from the behavior modification principles of sequencing tasks, shaping, modeling, repetition and consistent reinforcement. Similar principles are used to build social competencies. We believe that attention and physical affection are necessary to build trust and self esteem. Because these children are afraid of adults, the first step usually involves pairing physical affection are necessary to build trust and self esteem. Because these children are afraid of adults, the first step usually involves pairing physical affection

with an activity the child enjoys, and at the same time we try to mention something positive that the child is doing. As the child becomes relaxed, we gradually begin to use positive attention selectively to shape or increase desirable behaviors. The child is either ignored or removed from the classroom for breaking the rules.

Staff

Initially one teacher conducted the remedial and behavior classroom. In the third year, two teacher (at 60% time) were assigned to each classroom. Although this present numerous communication and coordination problem this checklist reduced the strain upon one teacher conducting two classrooms in one day.

There are two paid staff members plus students and volunteers in the remedial classroom. The classroom teacher has primary responsibility for planning and conducting or supervising the ongoing classroom activities. In addition she supervises and trains volunteers and students who work with the children, conducts individual prescription activities, and has responsibility for observing and recording classroom behavior. In contrast, the diagnostic teacher does not have ongoing classroom responsibilities. Her primary duties with regard to the morning program consist of diagnostic testing and periodic re-evaluation of children, supervising, planning and carrying out part of the prescriptive work, record keeping, and providing consultation and training for behavior interventions.

Teams of two student teachers or volunteers work with the classroom teacher each day making the child-teacher ration three-to-one. In addition to assisting the classroom teacher as needed, the student teachers plan and implement two complement activities such as art or story time. A total of nine students have been recruited from four local colleges and universities. Each attend an initial nine-hour training session and receives one-half hour of individual supervision and one hour of group supervision each week.

Parent(s) Involvement

We involve the parents in the program both formally and informally. Parent involvement in the children's program serves two primary purposes. We hope that by giving attention to the parents we can lessen the danger that they will become jealous of the attention their children are receiving. The second purpose is that interaction with the parents increases the staff's understanding of the problems encountered by both the parents and their children. This understanding in turn, is helpful both in diagnosing the children and in ensuring empathetic treatment of the parents.

Informally, we encourage parents to observe their children through one way mirrors. The children's staff also tries to make themselves available to parents when they call with questions about their children.

Formally we present a parents night program every 2 or 3 months. These programs cover such subjects as "discipline", "play", and "language development". A bi-monthly newsletter is also sent to parents that describes the programs current activities and events, program changes and announcements and activities the parents may try at home with their children.

Children's staff also attends the family conference of any child in the program to give parents information on their child's progress.

Evaluation and Record Keeping

The primary purpose of record keeping is to enable us to evaluate the child's needs, design treatment interventions, and assess progress. At intake, social and medical information are obtained along with permission forms and testing information. Ongoing record keeping consists of observations summaries by the diagnostic teacher. The gist of the evaluation is a quarterly progress review for each child which was done concurrently with BPA reports. At this meeting the entire children's staff used the weekly summaries plus any new testing information or information regarding the family to assess the interventions we have been using with a particular child and to formulate new treatment plans. When a child is terminated, a report of his or her progress, test information, and recommendations are compiled. This information is then available to referral agencies.

Impact:

(1) Academic Individual:

The children have achieved specific prescriptive goals at a rate of one to four per month. This varies depending on how many individual sessions are conducted. Evaluation is built into the prescriptive work as objectives are stated in observable teams. In addition to documented progress of specific objectives, informal observations suggest the children are using more complex language structures, initiating and completing cognitively oriented tasks, and some are beginning to work successfully with kindengarten readiness materials.

(2) Academic Groups:

Table provides a complete list of terminal objectives accomplished by one child currently in the program. As a result of sequential steps, the children seem more confident at trying new and difficult task. We have found that three of the children seem more confident at trying new and difficult tasks. This difficulty is attributable to poor verbalization skill, short attention span, and/or severe delay in development. For these children it would be more beneficial to write objectives from Portage Checklist.

(3) Social:

Staff Anecdotal Information - common changes observed in the children's behavior included more spontaneous expressive language, more appropriate affect (i.e. child appears happier, more smiles, etc.), improved self help skills; increased tendency to seek out adults for wants, needs, and affection, more social interaction with peers, and improved physical appearances (an indicator of improved parental care).

Retest Results

The retest results are shown in Table 15 -Table 17. These test reflect both children who have been terminated and children who remain in the program. Taken as a whole, the results do indicate progress, although interpreting the

Table 15

Retest Comparisons for Morning Program Children

Peabody Picture Vocabulary Test

Scale	Time	N	X	SD	t	P
IQ	1	16	70.25	9.95	4.65	.000
	2		88.81	14.95		

Table 16

McCarthy Scales of Childrens Abilities

Scale	Time	N	$\bar{X}$	SD	t	P
Verbal	1	14	39.07	9.77	.56	.587
	2		40.00	8.79		
Perceptual	1	14	38.86	10.66	3.13	.008
Perceptual	2		45.79	11.70		
Quantative	1	14	38.79	9.83	.69	.502
Quantative	2		40.21	12.23		
GCI	1	14	78.29	19.52	2.43	.030
GCI	2		83.86	20.24		
Memory	1	14	43.79	10.18	3.36	.005
Memory	2		39.50	9.30		
Motor	1	14	40.36	10.85	.44	.667
	2		41.79	10.48		

Table 17

Preschool Language Scale

Scale	Time	N	$\bar{X}$	SD	t	P
LAQ	1	13	82.62	16.42	2.50	.028
LAQ	2		93.62	24.14		

amount of progress and its practical significance is problematic.

Two factors seem relevant to the interpretation of the tests: (1) the difficulty of the test and (2) the amount of verbal response required. The PPVT focuses solely on language reception, while the perceptual scale of the McCarthy is only MCSCA subscale which does not require verbal response, the PLS is divided between receptive and expressive language. In contrast to the PLS and the PPVT, the McCarthy is a long test with a ceiling criteria that is liable to lead to feeling of frustration and anxiety. These factors combined with the observation that children showed statistical significant gains on the perceptual subscale of the McCarthy and losses on the memory subscale, suggest that the children have made small, stable gains in the receptive language and non-verbal areas.

From the above information, two speculations seem reasonable. If the task and situation do not arouse anxiety, the children may perform at a level that is only slightly below average. Conversly, if the children become anxious and/or need to give a lengthy verbal response, their performance will be noticably below that of an average peer group. Unless the children regress, however, special placement should not be necessary for the majority of them.

We know from the observations of social skills that the children are making progress interacting positively with both peers and teachers. In spite of this progress, however, the children as a group are still exhibiting behavior indicative of emotional distrubance on the Pre-School Behavior Questionaire. It seems probable that the children who are exhibiting hyperactive and/or aggressive behavior will encounter problems at school.

Functioning In a Public Day-Care or School Setting:

Unfortunately, we have not been able to follow-up children who have left the program. It is clear however, that not all children can be placed in regular day-care or school settings. Three children have been referred to classes for developmentally disabled students; one child is in residential care and another is in a day-care program for the emotionally disturbed. In addition, another boy was placed in Headstart so that he could be provided with daily transportation to speech therapy lessons. In all, one-third of the children in the morning program have been referred to some type of specialized program.

Summary:

The focus of the entire program can be described as "prescriptive". An attempt is made to match diagnostic and teaching procedures to the individual behavioral and cognitive needs of each child. Some abused children need a specialized remedial program which is designed to remediate developmental lags. It seems risky to assume developmental deficits will become assets with increasing age. The children have been making substantial gains in acquiring previously nonexistent or emerging skills, many of them are far from being developmentally competent individuals.

In summary we have found this approach useful in promoting skill development and self confidence. The children in general strive for successes and respond quite positively to our approach.

Recommendations:

(1) Our experience strongly suggest some abused children are in need of a structured program designed to remediate developmental skill deficits. A low teacher-child ratio is necessary condition for the individual work. A diagnostic person can function in a teaching role thus adding to the teaching personnel necessary to individualize instruction. For some developmentally delayed abused preschoolers progress is slow. Skills need to be shaped in small steps with attention to proper sequencing and the use of a variety of effective reinforcers. We have not found the structured nature of the program defimental to safe and warm emotional climate. The children seem much more stable in a structured setting where expectations are clear and successful performance, regardless how small, is reinforced.

(2) The use of diagnostic information should be of practical import for teaching staff. We have attempted to translate information into specific guidelines for remediation.

(3) To encourage social behavior between peers and adults, we have found it important to model the desired behavior and responses for the children throughout the day.

(4) Limits and rules should be clearly stated and followed by children and adults. This helps establish consistency within the program.

(5) It is important to have one head teacher throughout the year, who is able to direct students and volunteers toward a consistent program. Students can be taught the methods, but may vary slightly in their implemention.

Overview

This classroom program was developed for children who did not exhibit developmental delays but who did exhibit a variety of inappropriate and at times uncontrolable behaviors as reported by parents and others. The original design included a home visitation component to train parents in behavior management. Due to unexpected outcomes, as described in the impact section, the program is defined more accurately as a preschool enrichment program which can accomodate abused children with behavior problems.

Objectives

1. To facilitate positive social relationships with adults and peers by providing a stimulating and therapeutic preschool environment.

2. To facilitate positive parent-child interaction patterns.

3. To decrease children's problematic behaviors by providing a structured environment.

Population

The children enrolled in this classroom have varied over time. Primarily, this program has served children ages 3½ - 5 years whose overall abilities are commensurate with their age but who have (or are perceived by parents as having) emotional or behavioral adjustment problems. Several of the children, in addition to being perceived as problematic at home, presented management problems to community day care personnel. General problem behaviors reported by parents and other adults included: non-compliance, fighting with siblings and other children, cursing, over-activity, and unusual body movements (flapping arms, nervous twitching, etc.).

Of a total of twenty-two children enrolled in this program, 12 (54%) were targets of some type of abuse/neglect. Over half were receipients of both emotional abuse and neglect. The remaining children were siblings of the target child with a third identified as potential for abuse/neglect.

Program Design and Rationale

The primary purpose of this component of the program was to expand the children's social skills and enhance adequate emotional development. It was our intent that the children would learn to express their aggressive feelings appropriately and exhibit prosocial affective behaviors essential to functioning in a "school" setting. This goal would be accomplished by focusing classroom activities on identification and expression of feelings in a psychologically safe environment. We used teacher structured reinforcements in the form of praise, and material reinforcers for prosocial behaviors. Two distinct theoretical orientations were intentionally included in the program design: 1) emphasis on unconditional acceptance, expression of internal emotional states, change from within the child, and minimal teacher structuring of activities; 2) emphasis on modification of the external environment to produce change in the child by use of contingent reinforcement and focus on observable measurable behaviors and teacher

structuring of activities. Structured scheduling provided a stimulating and consistent classroom environment for the children.

Behavioral interventions (i.e., counting, charting and evaluating changes of specific child problem behaviors) will be implemented during the classroom period when appropriate. For example, if a child displays a high rate of hitting other children during free-play, that behavior will be observed and counted to determine how often it has occurred, and a plan will be devised to reduce the hitting and increase more positive responses. The child may be isolated briefly from the other children, following each occurance of hitting and, more importantly, will be praised and/or tangibly rewarded for exhibiting more appropriate behaviors toward the other children.

Staffing Pattern

Staff for this component included: the classroom teacher, diagnostic teacher, student teachers, and volunteers. The classroom teacher's responsibilities included planning and implementing the curriculum, implementing of behavioral interventions, training and supervising students and volunteers, and participating in the home component. Responsibilities of the diagnostic teacher included testing, designing and supervising classroom behavioral interventions, providing inservice training on behavior management, participating occasionally in the classroom and supervising and implementing the home component.

Initial Tests Results: Initial test results are presented on fifteen children in Tables 18 through 21. Scores on the Denver Developmental Screening Test (DDST) indicates 93% of the children scored normal and 7% questionable. In contrast, only 33% of the morning children scored normal (see Table 11). The mean score on the Peabody Vocabulary Test was 90, while the mean score on the General Cognitive Index of the McCarthy Scales was 93. Results from the Preschool Behavior Questionnaire showed that 38% of the children exhibited behavior indicative of emotional disturbance.

Classroom Schedule

The classroom schedule is shown in Table 22. This classroom schedule is revised from the previously two (see second annual report for description). Basically, it represents a reduced emphasis upon group discussion of feelings and free play to structured group activities and skill development. A description of the schedule follows.

Group sharing allows time for each child to share experience of recent happenings to him/herself or family members. The teacher focuses on recognition of names, colors. and numbers through a discussion of the day's upcoming activities. In addition, this discussion prepares the children and provides consistent structure.

Science time consists of specific lessons on topics such as: body parts (bones, muscles , breathing), first aid, plants, mirrors and reflections, colors, food groups, etc. The children are involved in experiments in both small and large groupings.

Table 18

Initial Peabody Picture Vocabulary Test IQ

	Afternoon Classroom
$\bar{X}$	90.00
Median	89.00
Range	71 - 117
Total N	15

Table 19

Initial Denver Developmental Screening Test

	Afternoon Classroom
Normal	93%
Questionable	7%
Abnormal	0%
Total N	15

Table 20

Initial Preschool Behavior Questionnaire:
Percent of Children Ranked Above 90th Percentile

	Afternoon Classoroom
Total Questionnaire	38%
Subscales	
Hostile	38%
Anxious	31%
Hyperactive	31%
Total N	13

Table 21

Initial McCarthy Scales of Children's Abilities:
General Cognitive Index

	Afternoon Classroom
$\bar{X}$	93.08
Median	85.50
Range	74 - 125
N	12

TABLE 22

Behavior Management Classroom Schedule

1:00-1:30	Staff prepare rooms and activities
1:30-1:35	Children arrive: greet children outside building, guided walk inside, store coats, etc., health check
1:35-1:45	Group sharing: discussion with children on their experiences and description of the day's schedule.
1:45-2:00	Science (Monday, Wednesday, Friday) Cooking (Tuesday, Thursday)
2:00-2:30	Free Play
2:30-2:50	Art (Monday, Wednesday, Friday) Pratical Life (Tuesday, Thursday)
2:50-3:00	Clean-up
3:00-3:15	Snack
3:15-3:45	Play Activities
3:45-4:00	Large Motor Activities, indoor or outdoor
4:00-4:10	Music
4:10-4:25	Story Time
4:25-4:30	Goodbye song, leaving

Cooking is a multipurpose component focusing on: 1) stimulating the senses, 2) tasting different or foreign foods, 3) strengthening fine motor skills, 4) introducing mathematical concepts. The children are engaged in peeling and slicing fruits and vegetables. On most occasions they prepare their own snack. During food preparation, the children count and measure various food items. Children are taken to fruit markets, grocery stores, and orchards to select their food.

Free play provides the children with an opportunity to select and work with a variety of materials (e.g. beads, cards, blocks, books, etc.) Positive interactions (child-child, child-adult) are facilitated. Cooperative play and verbal interactions are specifically reinforced.

Art time involves working with fingerpaint, crayons, beads, paper, water play, etc. The period allows teacher directed and child initiated activities. Art time encourages self-expression and social interaction.

Pratical life centers on developing the child's skills in zipping, buttoning, snapping, sewing and grooming. Particular emphasis is placed upon hygiene skills of washing, brushing, etc.

Play activities are both teacher and child directed. Activities include: dramatic play, dress up, housekeeping, role playing. As in free play, cooperation and verbal interaction are specifically reinforced.

Large motor activities involve both indoor and outdoor experiences. Climbing apparatus and mats are used indoors. Bikes, swimming, playgrounds, and hikes are used outdoors. Beyond the large motor exercise children are taught traffic signals and safety procedures.

Music provides a sensorial experience as well as developing memory, coordination, and listening skills. Various pieces of musical equipment are utilized. They include: tape recorder, record player, guitars, and playing instruments for the children.

Storytime provides a quiet activity as preparation for departure. Stories are selected which reinforce concepts taught during the day. The teachers engage the children in group conversation regarding the story.

Good-bye songs are signals for departure. Teacher and children review the day's events.

Parent Participation

The home component consisted of weekly one hour visits to the parents whose children were in the classroom. The purpose of these visits was to provide parents with help in managing specific problem behaviors of their children. (The process is described in the section on Behavior Management Counseling.) This component was considered essential to improve parent-child interaction patterns. In order for children to generalize appropriate behavior patterns from the classroom to the home, changes in parent response patterns to their children were needed. For this reason classroom participation for the child was contingent on the parent participation

in the home component. Parents who could not accommodate afternoon home visits were given a time at the Center in the evening.

Impact

The behavior management classroom serviced 22 children. The length of stay ranged from one month to ten months, with the average being 3.3 months. The majority of children entered kindergarten and first grade classes. Two children terminated as parents dropped out of treatment, two children were transferred to the remedial developmental and one to special school district.

Quite unexpectedly, most of the children after an initial adjustment period of one to two weeks, adapted well to the classroom environment and exhibited no significant behavior problems. Some charting of attending behavior in a group setting was done to detail a behavioral intervention. Children who met criteria for attending (eye contact, proper body orientation, etc.) were praised and those who did not meet the criteria were ignored. All of the children were attending over eighty percent of the time (under five minutes) after they hit another child. After one month in the program hitting was an infrequent occurrence. Simply stated these children who were expected to exhibit high rates of aggressive-disorganized behavior were not "problematic" children within the classroom environment. They exhibited behaviors quite appropriate for their ages. In fairness to parents, daycare and public school personnel these children did exhibit high rates of inappropriate behaviors in other settings. It seems that given consistent expectations and individual attention characteristic of the classroom, these children received adequate rewards for exhibiting more appropriate behaviors. It is also plausible that the severity of "problem" behaviors was overestimated by parents and other adults. Parents reports indicated that several of the children were moderately problematic at home.

For some children, the behavioral changes were difficult to maintain. Any change in routine (e.g. new child, teacher absent) would result in a demonstration of non-compliance and aggressive behavior.

Teacher anecdotal data collected weekly indicated three major changes in the children's behavior after one month in the program. 1) The children sought out attention from adults appropriately ie. not "acting out" or violating rules to call attention to themselves; 2) The children verbalized feelings more frequently to adults and peers as opposed to whining, throwing tantrums, etc.; and 3) The children followed the classroom routine with minimal conflict and also expressed enjoyment of the classroom.

Parent reports included the following general information about changes in their children: 1) The children were more "well behaved at home"; 2) The children fought less with siblings; and 3) Some parents reported an increase in the use of verbal problem solving and expressions of feelings in place of hitting, screaming, and throwing objects. The impact of the home component is discussed in the behavior management counseling section as this component was expanded.

In summary, the children's problems were much less severe than anticipated. The behavior management counseling component, which grew out of this classroom program, had a significant impact on the general goals for the project.

Recommendations

1. The demands placed by problem behavior children can be exhaustive for staff. Careful consideration should be taken in selecting staff who can withstand name calling, non-compliance, and physical aggression from children. For some children, it is unrealistic to assume that their behavior will decrease rapidly and/or remain absent. It is necessary to provide a highly structured environment maintained by a strong and stable staff.

2. Recommendations for the Behavior Management Training can be viewed in the Family Treatment component under the same title.

CHILD ABUSE MANAGEMENT

ST. LOUIS CHILDREN'S HOSPITAL

The Child Abuse Management Committe at SLCH existed as an informal structure at the Center's inception. The Coordinator of the Social Services Department (a social worker) and the Director of House Staff Training (a pediatrician) jointly managed the Committee. The Committee maintained an open membership to house staff (interns, residents, nurses, and social workers). The Committee met periodically to formulate policy and to define operating procedures. The purpose stated in the Center's grant is to establish a formalized system for the coordination of suspected child abuse cases within SLCH.

Goals

The goals of the Child Abuse Management (CAM) component are to:

1) Coordinate child abuse services within SLCH.

2) Educate medical staff on the identification of child abuse.

Description

The coordination of child abuse services within SLCH has involved the activities of the CAM Committee and the individual management of child abuse cases. Formalization of the Committee occurred with the Center allocating grant funds for part-time activity of the Head of House Staff Training and Social Services Coordinator and full-time activity of a social worker. These three staff established a care unit within the CAM Committee. This care unit selected other hospital personnel to participate in the CAM Committee. These members included nurses, house staff, a psychiatrist, and the director of ambulatory care. The CAM Committee met monthly to determine policy and operating procedures.

Specific areas of concern included: CAM record system, 24-hour call system managed by five physicians and two social workers, compliance with the new Missouri Child Abuse Law, and management of individual cases.

Previously, child abuse cases were assigned to social workers on a rotating basis. With the grant project, the full time social worker was assigned the position of CAM Coordinator. The Coordinator monitors the flow of communication within the Hospital on each case and provides crisis intervention, referral and follow-up services for parents, conducts monthly session for house staff and nurses who rotate through the emergency room, and maintains contacts with community agencies regarding individual cases.

TABLE 23

REPORT OF ABUSE CASES - ST. LOUIS CHILDREN'S HOSPITAL - MARCH 1975 TO FEBRUARY 1976

MONTH	TOTAL CASES	LOCATION			SEX		RACE		AGE		INJURY								REFERRED *				
		CITY	COUNTY	ILL.	FEMALE	MALE	WHITE	BLACK	0 to 3	3 +	CUT & BRUISE	BURN	HEAD	SEXUAL	FRACTURE	INJESTION	DEATH	OTHER	DFS	C&FS	COURT	FRC	OTHER
ARCH	11	8	3	0	3	8	3	8	4	7	7	0	0	1	2	0	0	1	1	0	0	4	1
PRIL	17	10	3	4	9	8	4	13	9	8	9	2	3	3	0	0	0	0	11	4	4	3	8
AY	11	8	2	1	4	7	0	11	6	5	2	6	3	0	3	0	0	0	10	1	1	2	0
UNE	14	12	0	2	7	7	4	10	10	4	6	2	1	1	1	0	0	3	11	3	3	1	2
ULY	7	3	4	0	6	1	2	5	6	1	2	3	2	0	0	0	1	0	5	0	0	1	2
UGUST	6	3	2	1	2	4	1	5	5	1	0	3	1	0	3	0	0	0	3	0	1	0	0
EPTEMBER	12	8	4	0	5	7	7	5	10	2	3	1	0	0	1	3	0	4	7	0	3	1	3
CTOBER	15	9	1	5	10	5	3	12	11	4	3	2	5	1	2	0	0	1	5	2	0	2	2
OVEMBER	12	8	3	1	7	5	2	10	11	1	6	2	0	0	2	0	0	2	8	1	0	0	3
ECEMBER	12	11	1	0	4	8	2	10	10	2	8	2	2	2	0	0	0	0	10	0	2	3	4
ANUARY	10	9	1	0	8	2	2	8	9	1	2	2	4	1	0	0	0	0	8	0	2	0	3
EARLY TOTAL	127	89	24	14	65	62	30	97	91	36	48	25	21	9	14	3	1	11	88	11	16	17	28
CASES	100%	70%	19%	11%	51%	49%	24%	76%	72%	28%	36%	19%	17%	7%	10%	2%	1%	8%	69%	8%	12%	13%	22%
VE./MONTH	11.5	8.1	2.1	1.2	5.9	5.6	2.7	8.8	8.2	3.2	4.3	2.2	1.9	.8	1.2	.27	.09	1	8	1	1.4	1.5	2.5

* DFS - DIVISION OF FAMILY SERVICES
C&FS - CHILDRENS & FAMILY SERVICES
FRC - FAMILY RESOURCE CENTER

TABLE 24

Distribution of Suspected Abuse Cases - St. Louis Children's Hospital

	Aug 1974 - Feb 1975	Mar 1975 - Feb 1976
Cases Identified	61	127
Geographic Location		
City Residents	31	89
County Residents	22	24
Illinois Residents	8	14
Disposition*		
Division of Family Services*	61	88
Juvenile Court	4	16
Children's Services	0	11
FRC	15	17
Other Community Agencies	7	28

* Due to concurrent referrals - total will not equal 61
* Mandated State Protective Agency

COMMUNITY AND PROFESSIONAL EDUCATION

The community and professional education component far exceeded the Center's initial projection. During the three year period the Center participated in 269 educational activities for professionals and community organizations. Five percent of these activities being outside the St. Louis metropolitan area.

Goals

The third goal of the Center is to provide a community education program which will:

1) Develop greater awareness of child abuse.

2) Improve the process of identifying and reporting suspected cases of child abuse.

3) Improve attitudes toward abusive parents and their children.

4) Encourage community support for programs serving abusive families.

Description

Originally, the Center planned to conduct educational programs for community and professional organizations on a limited basis. The Center did not plan to publicize the availability of speakers for educational presentations but rather to respond to specific requests. Although the Center did respond only to specific requests, the rate of requests increased from 24 in the first year to 85 in the second and 160 in the third year, (see table 25). This inflation resulted in the Center designing a formalized education program. The formalization of the program occurred mid way in the grant period. Initially, several project staff conducted sessions with various community and professional organizations. These included: civic groups, nurses, day care personnel, teachers, social workers, and volunteer associations. The content of these sessions focused upon: 1) etiology of child abuse and neglect 2) identification of child abuse and neglect 3) the Missouri child abuse law 4) services for abused children and their parents 5) Family Resource Center program.

With the increasing demand for presentations, the Center formalized the program with the addition of a unit of volunteer community educators. In December, 1975, five volunteers were recruited through the National Council of Jewish Women and the community at large to participate in a pilot project to train volunteer community educators. The training program provided the volunteers with 25 hours of initial training, observational practice and monthly in-service sessions Volunteers are assigned to primarily student groups and civic organizations. In addition, volunteers co-lead presentations with staff persons if appropriate. At the end of the grant, 11 volunteers participated in the program.

Table 25

ANNUAL DISTRIBUTION OF COMMUNITY EDUCATION ACTIVITIES

	Year I May, 1974 Feb., 1975	Year II March, 1975 Feb., 1976	Year III March, 1976 April, 1977	Total
Community Organizations	12	9	76	97
Student Groups	6	54	63	123
Television	3	9	8	20
Radio	2	8	10	20
Newspaper	1	5	3	9
Total	24	85	160	269

Volunteers and staff worked on designing package presentations to use with various groups. In addition, the Center purchased two films, and two slide presentations for use in the educational sessions through solicited contributions.

The range of presentations have included: police training seminars, church groups, hotline volunteer organizations, physicians, mental health professionals, and parent groups.

Impact

In assessing the impact of the educational program it appears that the Center has been most successful in increasing the awareness of child abuse. Requests for presentations are continually received. One of the main sources of requests appear to be organizations which have participated in previous sessions. With several organizations, the Center conducts on-going sessions. For example, the community education volunteers conduct a two-hour session with student nurses rotating through SLCH on a quarterly basis.

Media presentations have resulted in more than an increase in the awareness of child abuse as a community problem. Parents who abuse their children or who see themselves as having the potential to abuse have also become aware of child abuse as a family problem. Self-referrals account for approximately one-third of all referrals received at the Center. A significant proportion of self-referrals have identified media presentations as the source of their knowledge about the Center.

The extent to which the Center has improved the process of identifying and reporting suspected cases of child abuse is difficult to assess due to the lack of true indicators. The volume of reports can not be used because the state mandated agnecy enacted a 24-hour Child Abuse Hotline in August, 1975. This hotline system has generated an increase of over 800% in the number of suspected reports. The Center has actively engaged in publicizing the Hotline through media presentations, distribution of cards, pamphlets and posters, training sessions with community and professional organizations on identification and reporting procedures, and joint sessions with the state mandated agency. The principal session with the state agency being a two-day community conference attended by over 150 professionals. One indicator of the appropriate use of the Hotline is that in the third year, the Center received significantly less calls to report a case of suspected child abuse than in previous years. Attitudinal changes regarding abusive parents can be identified through the following: 1) Media programs have focused less on the "horror of the crime" and more on "these parents can be (and should be) helped", 2) Professionals have indicated an increased positive attitude regarding the potential to successfully intervene with abusive parents.

Perhaps, abusive parents themselves have been the most significant factor in improving community attitudes. The Center's parents have participated in nine radio and television broadcasts as well as three newspaper articles. Parents and audiences have identified this media

participation as having a meaningful effect for them. For parents, they most often identified the satisfaction of helping other parents. For audiences, the presentations helped them to understand that abusive parents are "real people with real problems".

The fourth area of impact can be assessed in the actual support community child abuse programs have received and to what extent FRC stimulated the support. In some respect this objective is self-serving. FRC has received support in the form of volunteers, donated resources, and financial contributions. The Center has also recruited professional and lay persons to organize and maintain three Parent's Anonymous groups in the St. Louis area. Other volunteers have been recruited to work with other agencies serving abusive families.

Issues

1. Understandably, the amount of time required to prepare presentations and to coodinate personnel and materials has been the major issue. Actual preparation gradually has reduced with the accumulated experience of each presentor as well as with the development of structured formats to be used with selected audiences such as nurses, students, etc. Coordination of the program has improved with the centralization of requests for presentations and media materials scheduled through one staff person.

2. Justifying the use of staff and volunteer time to conduct sessions versus providing client services has been a financial issue. The utilization of volunteers has greatly reduced the amount of staff time. However, administrative staff heavily engage in the maintenance of the volunteers. The Center decided that the community education program has served a vital purpose in the community and is continuing its efforts since the expiration of the grant period. The Center does request nominal fees for presentations and film rental to defray expenses.

Recommendations

1. Before implementing a community or professional education program, procure necessary materials (film, handouts, etc.) and provide sufficient training on content (child abuse) and on techniques of public speaking.

2. Develop an on-going inservice program for educators and/or trainees to review materials and to introduce new ideas.

The original research design included three components besides administrative tracking of clients and services. 1) Standardized testing and observations of children; 2) Content analysis of treatment; and 3) Standardized observations of parents and children. The last two components were deleted due to a lack of money, and time.

Emphasis was placed upon studying the children's characteristics, and the research coordinator worked primarily at monitoring record keeping, conceptualizing program components, and consulting with other staff members concerning program or procedural changes.

Objectives

Objectives for the research component are as follows:

1. Participating in the national evaluation
2. Developing a process for conceptualizing program components for dissemination of the FRC model to the field
3. Determining methods for measuring behavior change in parents and children
4. Testing and diagnostic assessment of target children
5. Identifying characteristics of our clients
6. Formulating admission criteria

Description

FRC participated fully in the BPA evaluation through the three years. As a whole, the project was very pleased with the procedures employed by the Berkeley Planning Associates. The evaluators encouraged feedback regarding the method and content of the evaluation. As the Center was one of a few projects providing services to children, the staff collaborated with the evaluators on the design of the Children's Progress Forms.

Staff response to the utility of the forms varied. Some felt the forms were useful for making initial assessments and charting client progress while others did not. It appeared that the utility of the forms was negatively affected by the number of forms to be completed. Project management employed incentives and structure to aide in the monthly completion of forms. However, both accuracy and completeness were problems with the adult client forms. Internal monitoring by research and management staff did not solve these problems. Another factor relating to the use of the BPA adult forms was that the project develop its own client forms, thus, requiring staff to complete two sets of forms.

In regard to specific forms, staff had three observations: 1) At the initial phase of intake, the reason for referral ie., the type of abuse/neglect is not always established. In the project's case most referrals were not often in the crisis stage, so that

an incident of moderate physical abuse or neglect in the recent history of the family was not identified by either parent or referral source. When this information was revealed sometime later in treatment, the intake form had frequently been removed from the file. 2) The global nature of the impact indicators bothered some workers. For example, a parent might make significant gains in dealing with a major aspect of the child's behavior, but still be unable to cope adequately with other major aspects of the same child's behavior. 3) Most staff members had difficulty assessing propensity for future aduse/neglect. Some staff members reported that they felt parents who had major gains in other areas had a strong potential for abuse/neglect primarily because the parents were still vulnerable to crises.

The Children's Progress Forms consisted of a different design than that of the adult forms. The forms were behaviorally oriented and identified specific behaviors and task areas. Although the forms required more time (approximately one and a half hours per child every three months), they provided staff with more measurable outcomes. After the conclusion of the evaluation, the project modified the forms which are currently employed as the primary assessment instrument for children in the preschool program.

2. Papers describing the developmental remedial preschool program, and the adult services program were read at national conferences and copies of the papers were sent to agencies that requested them. The adult program paper focused upon the sequence of services usually provided because it was apparent that modes of providing any given service (e.g. group or individual therapy) varied too much from worker to worker. The afternoon preschool program was never conceptualized because of continued variability in the program.

3. Instead of developing our own instruments to measure behavior change in clients, the project decided to supplement BPA's evaluation with two approaches. The children's program used standardized tests and a behavior rating scale at six month intervals to assess progress in the morning and afternoon programs. They also attempted to have parents who received behavior management chart specific behaviors of their children before and during interventions (see section on Behavior Management Counseling).

Attempts to have workers use goal attainment scaling were not successful because the technique is too complex and time-consuming. Workers did, however, become more skilled at writing goals in behavioral terms. This skill helped workers in carrying out the behavior management component and helped the project to realize the need for more behaviorally oriented interventions with parents.

In 1977, the project did attempt to contact terminated clients. Out of a list of 32 names - in spite of the fact that clients had not been terminated for more than 1½ years - graduate social work students were able to locate only five previous clients. The remaining clients had either moved without leaving a forwarding address or did not have a listed telephone and did not respond to letters. As might be expected, the clients who were contacted represented stable families who had maintained gains made in treatment and had not had any reincidence of abuse.

4. The project screened a total of 68 preschool children, 48 of whom were targets of abuse and/or neglect (see Section on Diagnostic for description).

5. Little work was done on these goals due to a lack of worker time to complete these forms. In order to study the differences between abusive and neglectful clients, the Washington University Sentence Completion Test [1] (a measure of ego development) was given to FRC clients who were receiving services (see Appendix II).

Issues

The primary problem experienced throughout the project was the lack of time and resources. Most effort went into completing BPA requirements leaving little time or energy for other projects. The primary reason the project was able to gather data on the children is that one full-time person was hired with the primary responsibility of testing. In other areas, workers did not see research related activities as their priority. If research efforts are to be successful in projects such as this one, they will require higher priority and/or the availability of assistants to help with data collection. In addition, if follow-up studies are to be successful, projects must remain in close enough contact with clients to be aware of addresses or to know of other people who can contact them.

1. Loevinger, T., & Wessler, R. Measuring Ego Development (Vol. 1, 2). San Francisco: Jossey Bass, 1970.

Psychometric Properties of the Tests: Some Notes

Table 26 shows the relationship of the screening tests - Peabody Picture Vocabulary Test and the Denver Developmental Screening Test to the General Cognitive Index - The McCarthy Scales of Children's Abilities. Because it has been observed that standardized tests may not be valid for abused children, the two screening tests were used to find the percentage of variance that they could predict in the McCarthy Scales. The McCarthy was given to children only after they had been in the Children's Program for approximately six weeks and were comfortable with both the setting and the tester. Thus, in addition to having a higher reliability than the screening tests, the McCarthy should provide a more accurate reflection of the children's abilities because it was given under more ideal circumstances.

For the purposes of the analysis, "normal" and "questionable" scores on the Denver were grouped together. As Table indicates, the two screening tests account for 75% of the variance in the General Cognitive Index of the McCarthy. Thus, at least for this small sample, the variance in the performance of abused children on a lengthy IQ test that is administered by a familiar tester in a known situation is largely predictable from the screening results. The results also indicate that it is probably reasonable to use the two screening tests to select pre-school abused children who are in need of special help. The estimated mean GCI for children who scored "abnormal" on the Denver was 70.0 while the estimated mean for children who scored "normal" on the Denver was 85.6.

Relationship of McCarhty General Cognitive Index to Child Characteristics

A stepwise multiple regression analysis was conducted using the Preschool Behavior Questionnaire, (a screening test for emotional problems) abuse/neglect status, age, and demographic characteristics (see Table 27) as predictor variables. Only the behavior questionnaire and physical abuse were significantly related to the General Cognitive Index, and both variables together accounted for only 43% of the total variance. Again, the sample is small and the results must be interpreted with caution. The results are interesting, however, for several reasons. 1) Although the causal direction is ambiguous, there is a significant relationship between physical abuse and the degree of emotional problems with abused children showing more disturbance then children who have not been physically abused. 2) Physical abuse has a negative effect upon the IQ test over and above that attributable to emotional disturbance. This effect may be attributable either to motivational variables not picked up by behavior questionnaire or to neurological damage associated with abuse. 3) At least for this sample, race and social class do not account for a significant proportion of the variance after that attributable to emotional disturbance have been partialed out. 4) Although emotional abuse has been said to have a significant impact upon the child, it was not a significant factor in this analysis. Possibly, this result is attributable to the fact the majority of these children were emotionally abused, thus providing little contrast between children who were emotionally abused and others.

Table 26

Screening Tests Regressed on the McCarthy General Cognitive Index

Correlation Matrix*

	DDST	PPVTIQ	MCGCI	$\bar{X}$	SD	N=20
DDST	1	-.5829	-.7415	.300	.4702	
PPVTIQ		1	.7988	75.550	13.500	
MCGCI			1	81.05	17.557	

	B	Beta	F	df	p.	Overall F	R^2
PPVTIQ	.72	.555	14.027	1/17	.005	25.9629 (2/17 df) p = .001	.75336
DDST	-15.60	-.418	7.946	1/17	.125		
Constant	31.18						

* The DDST is dummy coded with abnormal scored = 1.

Table 27

Relationship of McCarthy General Cognitive Index to Child Characteristics

Correlation Matrix

	PBQ	INJURY	MCGCI	$\bar{X}$	SD	N=25
PBQ	1	-.5414	-.566	17.32	9.9696	
Injury		1	.416	.44	.50	
MCGCI			1	82.08	16.69	

	B	Beta	F	df	p.	Overall F	R^2
PBQ	-.689	-.412	5.440	1/22	.05	8.41042 f.=.005	.32015
Injury	-12.189	-.370	4.392	1/22	.05		.43329

1. Non significant variables were: neglect, race, emotional abuse/neglect sex, mothers education, age.

2. The mean age at time of testing was 47.9 months (S D 8.78) for the McCarthy and46.6 (S D =9.46) for the Preschool Behavior Questionnaire. The mean score for the PBQ is at the 90 th percentile for the scale and is indicative of emotional problems.

Relationship of Change Scores to Original Scores

Table 28 shows the correlation of the change scores to the original scores. The correlations indicate that the changes on the Preschool Language Scale, the perceptual scale and the General Cognitive Index of the McCarthy cannot be attributed to regression of the scores towards the mean. That is, improvement on these tests did not come solely from children who may have scored abnormally low on the initial tests. In contrast, the initial Peabody Picture Vocabulary Test does have a negative correlation with the change score indicating that part of the improvement on this test may be due to some children scoring atypically low on the initial test.

Table 28

Correlation of Change Scores with Initial Test Scores

Test	r	p.	N
Peabody Picture Vocabulary Test	-.3401	.048	25
McCarthy: Verbal Scale	-.3918	.039	21
McCarthy: Perceptal Scale	-.2282	.160	21
McCarthy Quantitative Scale	-.2649	.123	21
McCarthy: General Cognitive Index	-.1882	.207	21
McCarthy: Memory	-.4383	.023	21
McCarthy: Motor	-.5133	.009	21
Preschool Language Scale: Total	.0289	.458	16

VOLUNTEER ACTIVITIES

Overview

The original design of this component consisted of recruiting volunteers from both the community and the univeristy sectors to be involved in the following areas: pre-school classroom, adult and child therapy, and child enrichment. With the expansion of the Center's programs, additional volunteer positions were created. These included: parent counselors, community educators, big brothers and a volunteer coordinator.

Volunteers both students and community persons contribute approximately 800 volunteer hours per month to the Center's programs. Needless to say, the absence of volunteers would significantly affect the range and volume of services the Center could provide. The Center's program is dependent upon volunteer input to provide services.

Description of Volunteers

Approximately 85% of all volunteers involved in the Center's program are women. They range in age from teenagers to a vigorous 70 year old grandparent. Most community volunteers are non-working white women, generally between the ages of 25 and 35, from middle and upper income families. They tend to have two to three young children. Almost a fourth of the volunteers are professionals in their own right, having degrees in education, psychology and social work. Minorites have represented only 4% of the total number of volunteers. University volunteers have represented the following disciplines: social work, law, psychology, education, and human service majors. Most students are from graduate schools. A total of 189 volunteers participated in the Center's programs. (see table 29)

Recruitment and Selection

Volunteers are recruited to the program through a variety of resources. These include: the National Council of Jewish Women, Volunteer Action Center, media announcements, neighborhood papers, and civic organizations. Media announcements produced the largest initial inquiries. The first announcements resulted in over 125 inquiries. However, the volunteers who actually are selected, trained, and assigned to positions from this source are far below the number from other sources - approximately 20% from media versus 70% from recruited sources.

Selection

The selection process is designed so as to allow both the perspective volunteers and the Center to decide whether the specific job is in his/her interest area. All volunteers are interviewed individually and complete a written application. The purpose of the interview is to explain the volunteer role and responsibilities and to ascertain whether the applicant is appropriate for the position. All volunteer positions have specific responsibilities.

Table 29

SUMMARY OF VOLUNTEER ACTIVITIES

ACTIVITY	Type			Total
	Undergraduate	Graduate	Community	
Adult				
Parent Counselors	0	0	22	22
Therapy Services	4	24	0	28
Recreational Services	3	1	0	4
Children				
Child Care	6	2	47	55
Remedial Preschool	42	7	6	55
Therapy Services	1	3	0	4
Community Education				
Educational Activities	0	3	8	11
Other				
Administrative	0	4	0	4
Legal	0	1	0	1
Medical	0	5	0	5
Total	56	50	83	189

Training and Supervision

All volunteers participate in initial and inservice training sessions and receive supervision. The extent of all three sessions is dependent upon the type of volunteer area. The training format consists of an initial 16 hour session for all volunteers followed by sessions for specific areas such as community educators, parent counselors, etc. Inservice training sessions are scheduled monthly for parent counselors and community educators and every three months for other volunteers. Students in placement participate in the Center's professional inservice sessions and receive weekly supervision.

Volunteer Roles and Responsibilities

Each volunteer position has a defined role and a specific area of responsibility. Position descriptions are distributed to each volunteer during the training session. The implementation of this system has provided a more effective volunteer performance as well as a clearer understanding of volunteer areas for paid staff. Activities of volunteers are described in the specific service category. The maintenance of the volunteers system has relied heavily upon a position established midway through the grant period. The volunteer coordinator has responsibility for recruitment and screening as well as shared responsibility for training supervision of volunteers. This position is also a voluntary position which involves about 15 hours per week. This position serves to maintain a well organized volunteer system.

Issues and Recommendations

We have found that developing and maintaining a volunteer system requires considerable planning to assure a positive experience for both the volunteer and the agency. These areas include: 1) the scheduling of recruitment so as to coincide with training sessions, 2) the method utilized for establishing an interface between volunteers and paid staff and 3) back-up systems for when volunteers are absent.

In order to conduct training sessions on a simi-annual basis, recruitment through media and organizations has to provide sufficient lead time so as to insure for an adequate screening period but not so long as to lose the interest of prospective volunteers. Generally, we coincide all recruitment four weeks prior to the actual training session.

We have found that it is imperative that the interface of paid staff and volunteer staff begin at the initial training stage. We include paid staff in the initial training sessions who present information, describe their specific job and/or conduct tours of the Center with the volunteers. We have found that this activity assists the two groups in understanding the role of each other and contributes to a more effective delivery of service by the Center as a whole. This interface is maintained through participation in joint activities such as agency meetings, training sessions, case staffings and special projects.

One basic issue that surrounds a volunteer program is what happens when volunteers are absent. Although some volunteer areas have back-up persons, most often paid staff have to perform the job. This results in

a shifting of workloads and often an acculumation of resentment if the staff person must continually perform in the role. Programs which are dependent upon volunteers may need to address this issue in specific terms for the consequences can be severe.

MAJOR PROGRAM ISSUES

Model Design - As discussed in the program description section, this program model incorporated a format of client and community services. These included: therapeutic services, evaluative research, community and professional education, volunteer training, coordination and hospital crisis intervention.

This design in itself presented the most significant issue for the project. The diversity and complexity of program design was inappropriate for a staff compliment equivalent to 8.5 professionals and 2 support staff. Although client services ranked highest in stated priorities, the extent to which this was achieved and the method of operation were directly affected by the development of the other program components. In addition, the very nature of the various program areas required specific areas of expertise and multiple responsibilities for most staff persons.

The basic atmosphere of the project at any one point in time could be described as the day to day deployment of available resources to handle crisis situations and routine tasks. Although the project preferred and attempted to develop a planned program, the reality was more aptly described as "blowing out the brush fires".

At times the project would utilize problem solving to determine alternative plans. Some sessions produced alternatives, others created additional activities. For example, the Center had anticipated the use of a limited number of volunteers to provide some client service. As the program necessitated greater resources than existed, a more extensive volunteer system emerged. This system resulted in contributing to the existing demands on staff instead of decreasing the demands.

Our experience suggests one or another design modifications which would produce a more effective and efficient program model. First, increase the staff complement to afford sufficient and qualified staff to conduct various program services. For instance, recruiting, training and supervising volunteers requires specific skills not commonly found in the repertoire of clinical personnel. Second, reduce the number of program areas a client services to be provided.

Of the two options, our recommendation is the retention of the entire program model intact and provide additional staff. It provides for an integrated program. Although the FRC grant writers themselves were fairly young and inexperienced, it was anticipated that more trained clinical and supervisory staff would be hired for the project. The staff made considerable efforts to recruit such staff. Unfortunately, low salary levels precluded affording the cost of these professionals. Thus, the project staff consisted of individuals who had minimum experience with half having one to two years of professional experience and others being recent graduates. Obviously, there are disadvantages and advantages.

The major disadvantage we encountered was what we may describe as a "hunt and peck" approach to treatment versus the touch type method.

Since the expiration of the grant, the Center has secured more experienced clinical personnel which has contributed to a more effective and quality based program.

Length of the Grant Period - The length of the demonstration period was 36 months. Prior to the grant award, FRC did not exist. Therefore the Center had to not only establish the program components but also formulate an operable organizational structure. This in itself is all quite normal and expected under demonstration grant conditions. The difference in the Center's grant period was the significant investment in the continuation of the project's services after the grant expiration. Thus, the Center's growth rate for the last 14 months was stopping and during the last six months was reduced.

It may be that grants awarded to new agencies may require a longer period such as four or five years. Although it is not conclusive that projects with six month start-up periods are any more developed at comparable times than projects without start-up times, it may be advantageous for some grants.

Continuation - For the last half of the project period the Center's continuation ranked as the number one priority. The Center allocated considerable time and resources to the continuation process. As a result the project administration had less time for the program management. Several clinical staff members were also engaged in this activity.

An additional aspect of the continuation was the cloud of uncertainty-would the project continue? This uncertainity manifested itself in the following: two staff initiated terminations, referrals were closed, confusion emerged among social agency personnel as to the Center's future, no vacancies were replaced, and uncertainity prompted anxiety in both parents and staff.

FRC did survive this phase, but not without a set back to the program's development which required almost a year to stablize all program components.

CONTINUATION

Midway in the grant period, the project staff began planning for continuation of the project. The inpetus for the grantee organization planning occured when the Center's sponsor, St. Louis Children's Hospital indicated that they would not be able to fund the Center after expiration of the grant period. The Center's services were non-medical in nature, and as such could not be funded by the hospital. Based on a mutual decision by the Hospital and project administration, the Center initiated steps to establish a not-for-profit corporation with an autonomous Board of Directors. This corporate and management construction allowed the Center to apply to various funding sources which would allocate monies to social agencies but not to medical institutions.

The primary objective of the continuation was to establish a funding base which would not be dependent upon a sole source of income such as a federal grant. Rather to establish a base which would have multiple and varied sources of income. With this objective, the project administration initiated a search of governmental (federal & state), private, and organizational generated (program. consultation, & client fees) funding sources. Two principal sources emerged: Title XX and United Way. The Center submitted applications to each agency within a time schedule which would coincide with the grant period expiration. Unexpected difficulties arose at the final approval phase with both sources. With Title XX funding, new appropriations passed by the Missouri legislation required the state to implement multidisciplinary purchase of service contracts for abuse and neglect families. This revision created a five month delay in securing a contract. With United Way, a misconception regarding the use of Title XX monies and the Center's history as a federal administration project resulted in a 12 month delay in funding.

As a consepuence of these tow factors, the Center launched a campaign to raise funds for an interium funding period. The campaign involved: solicitation of foundation and individuals. media appeals for contributions, fund raising events by staff and parents. These activities resulted in the Center raising 41% of its annual budget ($60,000) to operate for this interium period.

Currently, the Center has three major sources of income which account for approximately 80% of its budget requirements. They are: United Way, Missouri Division of Family Services, Office of Education, DHEW. The remaining is raised through organizational generated income and contributions.

In summary, the continuation was successful. (see Major Program Issues for additional information).

STANDARDIZED AND INFORMAL INSTRUMENTS UTILIZED: CHILDREN'S PROGRAM

TEST NAME	AUTHOR(S)	PUBLISHER	AGE RANGE	PURPOSE	FOCAL AREAS: COGNITIVE	LANGUAGE	GROSS MOTOR	FINE MOTOR	PERSONAL/SOCIAL	SELF-CONCEPT	BEHAVIOR	INTELLIGENCE		UTILITY FRC	UTILITY CODE
The ABC Inventory	N. Adair G. Blesch	Research Concepts Test Maker, Inc.	4 - 6 years	designed to identify children not likely to fail in kindergarten or not likely to be ready for grade one	memory	X	X		X					S - limited use - not standardized	S - screening B - baseline intervention O - ongoing intervention evaluative T - termination (G)eneral - overall ability function level (Sp)ecific- translating into specific function treatment goals
Portage Project Checklist	David Shearer, et., al.	Cooperative Educational Service Agency #12., Portage Wisconsin	birth to 5 years	A checklist of Developmental skills divided into 5 areas - good synthesis of several developmental scales		X	X	X		X			self-help	B, O extensive use not standardized	

* The Valett Developmental Survey has been dropped from the test list of last year as it was too time consuming and duplicated information obtained on other tests.

** The Mississippt State University Language Development 1-6 Checklist was used for a time but also duplicated information sufficiently covered on other instruments.

STANDARDIZED AND INFORMAL INSTRUMENTS UTILIZED: CHILDREN'S PROGRAM

TEST NAME	AUTHOR(S)	PUBLISHER	AGE RANGE	PURPOSE	FOCAL AREAS: COGNITIVE	LANGUAGE	GROSS MOTOR	FINE MOTOR	PERSONAL/SOCIAL	SELF-CONCEPT	BEHAVIOR	INTELLIGENCE		UTILITY FRC	UTILITY CODE
Primary Self-Concept Inventory	D.G. Muller R. Leonetti	Learning Concepts	Children grades K - 4	Designed to provide an economical procedure for evaluating several aspects of self-concept relevant to school success.						X				S (School-age children) C limited use limited standardization	S - screening B - baseline intervention O - ongoing intervention evaluative T - termination (G)eneral - overall ability function level (Sp)ecific- translating into specific treatment goals function
Piers-Harris Children's Self-Concept Scale	E.V. Piers D.B. Harris	Counselor Recording and Tests	Grades 3-12	Self Report instrument designed primarily for research purposed about self concept development - gives report of how child reports he/she feels about themselves.						X				S(school age children) limited standardization limited use	
Developmental Test of Visual-Motor Integration	K.E. Berry N.A. Buktenica	Follett Publishing Co.	2 - 15 years	Assesses the degree to which visual perception and motor behavior are integrated - paper and pencil test	visual perception				X					newest addition not in use currently probable utility: B, O, T =G&S limited standardization	

STANDARDIZED AND INFORMAL INSTRUMENTS UTILIZED: CHILDREN'S PROGRAM

TEST NAME	AUTHOR(S)	PUBLISHER	AGE RANGE	PURPOSE	FOCAL AREAS: COGNITIVE	LANGUAGE	GROSS MOTOR	FINE MOTOR	PERSONAL/SOCIAL	SELF-CONCEPT	BEHAVIOR	INTELLIGENCE	UTILITY FRC	UTILITY CODE
Receptive Expressive Emergent Language Scale (REEL)	K. R. Bzoch & R. League	The Tree of Life Press	birth to 3 years	measure of receptive and expressive language - useful for clinical evaluation and treatment assessment		X							S -for children 2 yrs.& younger limited use FRC. standardization in progress	S - screening B - baseline intervention O - ongoing intervention evaluative T - termination (G)eneral - overall ability function level (Sp)ecific - translating into specific treatment goals function
Slossen Intelligence Test (SIT)	R. L. Slossen	Western Psychological Services	2 wks. - adult	individual intelligence screening test yielding mental age and I.Q.		X						X	S, B = G limited use standardized	
Northwestern Syntax Screening Test (NSST)	Laura Lee	Northwestern Univ. Press	3 - 8 years	Quick estimate of a child's syntactic development - isolates children sufficiently deviant to warrant further study.			X						New addition not determined - probably: B,T = G standardization in process	

STANDARDIZED AND INFORMAL INSTRUMENTS UTILIZED: CHILDREN'S PROGRAM

TEST NAME	AUTHOR(S)	PUBLISHER	AGE RANGE	PURPOSE	FOCAL AREAS: COGNITIVE	LANGUAGE	GROSS MOTOR	FINE MOTOR	PERSONAL/SOCIAL	SELF-CONCEPT	BEHAVIOR	INTELLIGENCE			UTILITY FRC	UTILITY CODE
Preschool Language Scale (PLS)	I. L. Zimmerman, V. G. Steiner & R. L. Evatt	Charles E. Merrill Publishing, Co.	1¼ - 7 years	designed to detect language strengths and deficiencies-based on normative developmental data - 2 scales: Auditory Comprehension and Verbal Ability		X									S -if child's developmental staus is questionable B, O, T - C&S not standardized	S - screening B - baseline intervention O - ongoing intervention E - evaluative T - termination (G)eneral - overall ability function level (Sp)ecific- translating into specific treatment goals
Developmental Profile (DP)	G. Alpern & T. Boll	Psychological Development Publications	6 mos. - 12 years	Developmental screening and programming (with child under 6 yrs. primarily). Inventory of skills	X	X	X	X	X			rough estimate			S -limited use-useful if child is untestable directly B, T - C&S New addition to battery is standardized	
Verbal Language Development Scale (Revised) (VLDS)	Merlin J. Mecham	American Guidance Service, Inc.	1 mo. - 15 years	informant interview scale of verbal language development - to assess what a child does in his/her daily life. Communicative activities - extension of communication portion of V.S.M.S		X									B, O - C limited use superceded by the PLS standardized	

STANDARDIZED AND INFORMAL INSTRUMENTS UTILIZED: CHILDREN'S PROGRAM

TEST NAME	AUTHOR(S)	PUBLISHER	AGE RANGE	PURPOSE	FOCAL AREAS: COGNITIVE	LANGUAGE	GROSS MOTOR	FINE MOTOR	PERSONAL/SOCIAL	SELF-CONCEPT	BEHAVIOR	INTELLIGENCE	memory	perceptual percept.	UTILITY FRC	UTILITY CODE
McCarthy Scales of Children's Abilities (MSCA)	Dorothea McCarthy	The Psychological Corporation	2½ - 8½ years	designed to determine general intellectual levels as well as strengths and weaknesses in important abilities	X	X	X	X							B, O, T - GAS standardized	S - screening B - baseline intervention O - ongoing intervention evaluative T - termination (G)eneral - overall ability function level (Sp)ecific- translating into specific treatment goals
Illinois Test of Psycholinguistic Abilities (ITPA)	S. Kirk, J. McCarthy, W. Kirk	University of Illinois Press, Inc.	2 - 10 years	emphasis on identification of major psycholinguistic strengths and weaknesses. Assesses 12 aspects of psycholinguistic functioning		X									B - selected use - with 3 children to date - some subtests administered to others. GAS standardized	
Preschool Behavior Questionnaire (PBQ)	L. Behar & S. Stringfield	University of N. Carolina	3 to 6 years	screening for symptoms or constellations of symptoms that suggest the emergence of emotional problems							X				B, O, T - C standardization in progress	

APPENDIX II

A PILOT STUDY OF PSYCHOLOGICAL IMMATURITY IN ABUSIVE AND NEGLECTFUL PARENTS*

Marcia Lange

Although the role of poverty in child neglect cannot be ignored (Kadushin, 1974), parental personality factors are frequently considered primary contributors to neglect. In particular, Polansky and his associates (Polansky, Borgman, and DeSaix, 1972) have found that infantilism or gross immaturity is a frequent problem of neglectful parents, and Polansky (1976) has argued that immaturity is one of the major causes of neglect (see also, Bandler, 1976; Sullivan, Spasser, and Penner, 1974). The purpose of this study was to further explore the association of immaturity with child neglect by comparing neglectful, abusive, and potentially abusive parents on Loevinger's stages of ego development (Loevinger & Wessler, 1970; Loevinger et al., 1970).

Briefly, Loevinger (1976) views ego development as a person's framework of meaning which is subjectively imposed upon experience. Aspects of this development include impulse control, interpersonal style, conscious preoccupations, and cognitive style. Ego development, then, refers to a person's customary frame of reference. The stages of ego development form an invariant sequence which is defined independently of age. Any individual can fail to develop beyond a given stage, and adults can be described by features of the stage at which their development ceased.

Although the sentence completion test can measure six stages and three transitional phases of ego development[1], the most important distinction for purposes of this paper is between the first two stages of development (impulsive and self-protective) and the conformist stage. At the impulsive stage, the earliest stage which can be measured, people do not recognize the existence of rules. Punishment or reward determines whether an action is "good" or "bad". People at this stage may be extremely dependent upon others, and they tend to be preoccupied with their own physical needs. Others are viewed primarily as a source of supply. People at the self protective stage do recognize the existence of rules. They are controlled by the fear of being caught and morality is judged by whatever happens to be expedient. They are exploitive, manipulative, and preoccupied with their own wishes and gaining control of

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1 The stages including transitional phases are as follows: impulsive, self-protective, transition from self-protective to conformist, conformist, conscientious-conformist, conscientious, transition from conscientious to autonomous, autonomous, intergrated. The transition from self-protective to conformist is described in Hauser (1976).

others. In contrast, at the conformist stage people stress obedience to external rules or social norms (transitional phase) and feel guilty if they break these rules. Their interpersonal style is one of superficial niceness, and they are concerned with social acceptability and appearance.

It was anticipated that parents who neglected their children would tend to score below the conformist stage on the sentence completion test. While, as a group, the abusive parents would score at or above the conformist stage.

Method

Subjects for this study were 42 parents who were receiving services from the Family Resource Center. Eighteen of the parents had physically abused their children; 12 had physically neglected their children[2], and 12 parents were considered to be potentially abusive. Fifty-eight percent of the neglect group and 56 percent of the abuse group were receiving Aid to Dependent Children (ADC), while only 8 percent of the potential abuse group were dependent upon ADC. Source of income was unknown for one abusive and one neglectful parent. Educationally, the abusive group resembled the potentially abusive parents. Only 27 percent of the abusive and 33 percent of the potentially abusive parents failed to complete high school. In contrast, 67 percent of the neglectful parents did not finish their high school education. The neglectful parents had a mean age of 25, and the other two groups had mean ages of 30. Fourteen parents were black and all except five were females.

All parents completed the Washington University Sentence Completion Test. Each protocol was assigned a code number. The protocols were then typed and items were separated from the context of the individual test. Responses were scored along with tests given to other populations by raters who were blind regarding the source of the protocols.

Results

Results for both the abuse and neglect groups ranged from the impulsive stage to two stages above the conformist stage (conscientious). The potential abuse group results started at the transition between self-protective and conformist stages and again ranged to the conscientious stage. However, 58 percent of the neglectful parents were at the impulsive or self-protective stage as compared to 17 percent of the abusive and 8 percent of the potentially abusive parents.

The difference in ego levels between the groups is statistically significant $F(2,39) = 5.116$, $p < .01$. The mean ego level for the neglect group was between the self-protective stage and the transition from self-protective and conformist stages, the mean for the abuse group was at the conformist stage, and the mean for the potential abuse group was at the conscientious-conformist level. However, the difference becomes marginal if educational level is used as a covariate, $F(2, 38) = 3.266$, $p < .05$, and disappears when both education and age are used as covariates (see Table A,B).

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[2] All except three of the neglectful parents also abused their children.

Table A

ANACOVA FOR EGO LEVEL

Factor	SS	df	ms	F	p.
Education	36.511	1	36.511	15.399	.000
Age	5.902	1	5.902	2.489	>.10
Abuse/Neglect Status	8.341	2	4.170	1.758	>.10
Residual	87.721	37	2.371		
Total	138.475	41			

Table B

Pearson Correlations [a,b]

	Age	Abuse/Neglect	Ego Level
Education	.218	.335*	.536***
Age	1.0	.306*	.316*
Abuse/Neglect		1.0	.434**

a. N = 42
b. Abuse/neglect status was coded to have a linear relationship with ego levels.

* $p \leq .05$
** $p \leq .01$
*** $p = .001$

DISCUSSION

Although immaturity as measured by the Washington University Sentence Completion Test is neither sufficient nor necessary for parents to be neglectful, these results do provide moderate support for Polansky's agrument that neglectful parents tend to be immature. Ego levels for the abuse and neglect groups had identical ranges, but 58 percent of the neglectful parents were at the two lowest stages as compared to 17 percent of the abusive parents & only 8% of the potentially abusive parents. Given that Loevinger's model predicts cognitive rather than overt behavior, and there are many potential causes of neglect other than immaturity (eg. drug dependency, depression, retardation, etc.), the results are better than might be expected.

There is no particular reason to believe that immaturity as defined by age should be related to neglect or the test results. In the group that was studied all parents were 21 or older. The problem of the relationship of SES and poverty to neglect, however, is still not resolved. Although similar percentages of abusive and neglectful parents were living on ADC, not enough information about the incomes of those supported by jobs was available to say that either group was living beyond a poverty level.

In addition, education did account for part of the relationship between abuse/neglect status and ego level. Both poverty and immaturity potentially can be viewed as factors partially underlying all three variables. The groups would have to be carefully matched on the SES variables to insure that any relationship between neglect/abuse status and ego level is not spurious.

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